U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEARS 2025 AND 2026

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEARS 2025 AND 2026

THURSDAY, APRIL 11, 2024

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

The committee met, pursuant to notice, at 9:03 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, Franklin, Van Orden, Luttrell, Ciscomani, Crane, Self, Kiggans, Takano, Brownley, Levin, Pappas, Mrvan, Cherfilus-McCormick, Deluzio, McGarvey, Ramirez, Landsman, and Budzinski.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. Good morning. The committee will come to order. Now I want to welcome Secretary McDonough to review the U.S. Department of Veterans Affairs (VA) budget request for 2025 and 2026. I want to let everyone know that we are expected to recess about 10:30 for the Japanese Prime Minister to address the joint session and then we will resume the hearing after that. I want to thank all the witnesses for their patience when we are dealing with this situation so I want to get right to it.

So you know, the President's request, $369 billion for the VA Fiscal Year 2025. Now, that is a nearly 10 percent increase from this year. In March, Congress already appropriated the vast majority of the 2025 funding or $295 billion. In June of last year, Congress already appropriated $24.5 billion for toxic exposure fund for 2025.

We are here today considering the remaining VA account for 2025 and the advance request for 2026. Congress is all always—I want to say this real clear. Congress has always prioritized veterans and met VA needs. In fact, for the most part the Department already has received their funding for Fiscal Year 2025.

I do not want to hear any more baseline rumors and scare tactics about Congress cutting off support for veterans like we heard last year. It is disrespectful to the men and women who have served our great Nation to spread lies in an attempt to score political points. I will not—we will not go. We cannot. I want to have a serious conversation about how VA is managing their taxpayer dollars that Congress provides.

There is a real problem here. Somehow, despite the nearly $17 billion increase this year and $33 billion requested for next year, the second largest Federal agency can barely keep its lights on. Hiring has been cut back or frozen. The healthcare workforce is shrinking by 10,000 positions. Construction to modernize the VA facilities has flatlined to only two major projects. Information Technology (IT) investments have been cut by 99 percent. Some existing projects barely have enough funding to continue and new projects are off the table.

The White House seems to be shortchanging many of the priorities that President Biden presents in his own budget and many of our priorities as well. The overall request increase is large, but a lot of the money seems to be in the wrong places. The simple explanation is that VA used the enhanced pay authority that Congress provided in the The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act and elsewhere to spend themselves into deficit.

In many VA offices they can no longer afford the employees they have now, much less recruit talented new ones. It is the opposite of what Congress intended when we provided these authorities.

I absolutely support the PACT Act, but VA implementation of parts of the law is getting very confusing. We are hearing from some Members' offices that the VA medical centers (VAMC) do not even understand the new eligibility criteria or veterans.

The whole VA budget is reliant on gimmicks that get more and more complicated every year. I am talking about transfers, carryovers, transformation funds, unfunded requirements, doing away with the second bite for healthcare, and a mandatory construction account that does not exist.

Yes, despite Congress' intent, VA is using toxic exposure funds as another budget gimmick. They are shifting regular expenses out of the baseline budget, dumping them into toxic exposures fund. Like it or not, 40 percent of the toxic exposure funds is community care. The VA budget simply does not have to be this complicated, especially because, unlike the Federal agencies, Congress always found ways to provide VA—prioritize VA. We always have and I am confident that we always will.

I have faith in the Appropriations Committee to sort out the VA's accounts. We have to do our part, too, as the authorizing committee. I want effective programs and realistic estimates. I want the dollars to actually benefit the veterans, family members, and survivors. We always have to stand guard against growth in the bureaucracy.

We have in front of us one of the most confusing VA budgets I have ever seen. Somehow a 10 percent overall increase contains a lot of cuts in a lot of different areas that, frankly, do not make sense, but I am committed to protecting healthcare and benefits. I hope we work together to do that.

With that, I want to thank Secretary McDonough and his representatives and the representatives of Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW), who will also be testifying on the second panel.

With that, Ranking Member, I now recognize you for your opening statement.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Well, thank you, Mr. Chairman. Today we welcome Secretary McDonough and veteran service organization representatives of the independent budget (IB) to discuss the Department of Veterans Affairs' budget request for Fiscal Year 2025.

Budgets reflect our priorities. That is true in how we spend our money and our time. This year's request from the President of three of $369.3 billion in funding for the Department of Veterans Affairs is a 10 percent increase over Fiscal Year 2024. There is no secret that the VA's budget has grown significantly since the start of the global war on terror, but this is a feature, not a bug.

President Biden's budget for Fiscal Year 2025 illustrates a key pillar of his unity agenda to support veterans. This year's requested increase reflects the President upholding promises made to those who have served since 9/11 and is a step in the right direction to care for aging Vietnam veterans.

During the last year, the PACT Act has expanded VA healthcare and benefits to millions of veterans exposed to toxins and other hazards. VA has approved more than 862,000 PACT Act-related claims, and more than 400,000 veterans have newly enrolled in VA healthcare.

Last year, VA also permanently housed over 45,000 homeless veterans, provided suicide prevention emergency care for over 50,000 veterans thanks to the Veterans' Comprehensive Prevention, Access to Care and Treatment (COMPACT) Act. Expanded services for veterans at risk of suicide delivered an all-time yearly record number of healthcare appointments and so much more.

Now, this is just the start of what we can accomplish with a well-funded VA. However, we know that Republicans have a different vision for VA. Their chosen Presidential candidate's plan as laid out in his project 2025 proposal will mean the end of the VA as we know it. It means a spoils system that doles out contracts to corporate interests and it means the privatization of VA healthcare. Let me repeat that. It means the privatization of VA healthcare.

When VA does well it does really well. VA outperforms the private healthcare sector in terms of quality and patient satisfaction while my Republican colleagues continually push a narrative of supposed failure that is not based on reality and is not based on the reality of many veterans.

Just recently, a Vietnam veteran who receives his care at VA let me know how much he values it. In response to congressional efforts to erode that direct care the veteran told me, "Don't let them mess it up." As such, I am alarmed to observe the growth in community care budgets since the Trump administration implemented new access standards in 2019.

VA's healthcare budget is out of balance and rather than directing billions of dollars to the community, we must provide VA with the necessary resources and staffing to ensure that direct care is robust, modern, and meeting veterans where they are.

We need to continue to do more to house our homeless veterans and continue to provide VA the ability to hire more staff to meet

the demands of more veterans using VA healthcare and benefits. Community care is more expensive than direct care. If we were truly concerned about the cost and fiscal responsibility we would invest more in direct care as it is less expensive and most effective for veterans.

Now, this is my 12th year in Congress. In my first year we dealt with the Phoenix wait time scandal. I was part of the negotiations on the Veterans Choice Act. As part of that we saw that Phoenix, like many other places in this country, struggled with a shortage of healthcare providers both at VA and in the community.

In the Choice Act I championed a provision that increased the number of medical residency spots at VA by 1,500 positions. This is helping to increase the supply of physicians both at VA and the community and this is why investing in VA is so important.

I know that ramping up VA's internal capacity is not simple. It will take time to bring veterans back from the community and into VA care, but it is something we must do.

I am sure we will hear today Republicans continue to be mouthpieces for extreme ideologies that amplify messaging that VA healthcare should be privatized. That is the direction we are headed if we do not take the time, provide the funding, or proceed with thoughtfulness to rebalance direct care and community care.

I look forward to hearing from Secretary McDonough and our Veterans Service Organizations (VSO) partners today, and I yield back.

The CHAIRMAN. I thank the ranking member for his comments. Even though some probably are not right, but that is all right.

Secretary McDonough, I am going to swear you in now if you would. Would you please stand and raise your right hand? You were way ahead of that.

[Witness sworn.]

The CHAIRMAN. Thank you and let the record reflect the witness has answered in the affirmative.

Now I would like to recognize Hon. Denis McDonough for 10 minutes for his opening remarks. Thank you again for being here.

STATEMENT OF DENIS MCDONOUGH

Mr. MCDONOUGH. Chairman Bost, Ranking Member Takano, and distinguished members of the committee, thank you very much for the opportunity to testify today.

Sergeant First Class Constance Cotton served honorably in the United States Army, including in combat during the Gulf War. She is a survivor of several incidents of military sexual trauma, MST. She shared her story of MST with pastors and with lay leaders.

Eventually she was connected to the VA in Philadelphia and its chaplain, Reverend Chris Antal, and Vet Center counselor Renee Smith. For nearly a decade, Chaplain Antal has helped Constance heal from all her injuries, while Renee has helped her deal with post-traumatic stress. Constance lives in New Jersey, but chooses the Philadelphia VA and Vet Center for her care.

She says, "I like that they really understand the challenges that veterans face." She goes on, "I am a walking miracle. They helped me—helped to give me a sense of community again."

We owe vets like Constance, and all vets, including the many vets on this committee, our very best. We are fighting like hell to give them exactly that. We are delivering more care and more benefits to more veterans than at any time in VA's history.

Over the course of the last year we have enrolled over 400,000 new vets in VA healthcare, 30 percent more than the previous year and an increase in each of the 50 states of this awesome Republic. Over 6.5 million vets had 118 million clinical visits, 47 million in the community, 42 million at VA, 29 million via VA telehealth. The last data point bears repeating. Millions of vets use VA telehealth.

Now on to benefits. We have decided over 1.9 million claims shattering the previous year's record by 16 percent. You have all heard of vets' frustration with Compensation and Pension (C&P) exams, justifiable, but in the last year we processed 2.4 million C&P exams, a record by nearly 30 percent and took an average of 31 days to complete them.

In total, we delivered $163 billion in earned benefits to over 6 million veterans and survivors, another record. The PACT Act has opened the doors to millions of toxic exposed veterans and their survivors bringing new generations of vets to VA healthcare and expanding benefits for many more.

The PACT Act is also delivering additional benefits for vets, the GI Bill, Veterans Readiness and Employment (VR&E), homeownership, survivor's pensions, and so much more, benefits that not only improve veterans' lives, but strengthen the American economy. We still have a lot of work to do.

The President's proposed budget fully funds VA so we can continue doing that important work. This budget is also about preventing veteran suicide, ending veteran homelessness, supporting healthcare for women vets, modernizing our IT systems, processing benefits, and honoring vets with eternal resting places.

No single investment is more critical to veterans that we serve in VA's future than the people we hire and retain. We hired at record levels last year, onboarding teammates like Rose Zundel, one of VA's newest Registered Nurses (RN). Rose spent 20 years working as a nurse in her community, but she chose to come to VA to serve vets like her dad and her grandpa. That is the kind of deep devotion that characterizes VA clinicians.

Rose said that she is grateful for the critical skills incentive (CSI) that she received, that it shows VA's commitment to supporting its employees and that she hopes 1 day to retire with VA. The work of caring for the brave men and women who fight our wars and their families, survivors, and caregivers is in full swing and continues to grow.

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems an Strengthening Integrated Outside Networks (MISSION) Act, COVID pandemic, and the PACT Act, all of these are products of just the last 6 years and any one of them would have been monumentally challenging. Together they have changed the healthcare landscape and the statutory basis for the work at VA.

As I said, any one of those on their own would have led to monumental change. Together they represent a seismic shift in the way veterans receive care and benefits. The way they change—they

have changed the way we do business creating enormous opportunities for veterans at VA. Right now we are at a critical moment for shaping and securing the future of veteran healthcare in America.

We will work to reliably offer a VA care option to every veteran, even vets who qualify for community care under the Mission Act. We want to bring as many vets as possible into our care because study after study shows that vets do better at VA. We have made considerable progress, whether in person, via telehealth, in our community living centers, mobile medical units, elsewhere, vets can access VA care at almost every turn.

What we do this year and over the next several years, building on the generosity of Congress in the last many years and the innovative hard work of VA's workforce, the best in the Federal Government, will determine what vets can expect from VA and how we deliver that high standard of care well into the future. This budget is the next step to continue delivering more care, more benefits to more vets for generations to come.

We look forward to collaborating even more effectively with you to build on what is working and to fix what is not. Thank you. I look forward to your questions.

[THE PREPARED STATEMENT OF DENIS MCDONOUGH APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Secretary. The written statement of Secretary McDonough will be entered into the hearing record. Now, we will start on questions and I now recognize myself for questions.

Secretary McDonough, the Fiscal Responsibility Act exempted veterans' healthcare from any cuts, yet that is where you have had a hiring freeze and the biggest budget problems. Can you explain why, what that is doing?

Mr. MCDONOUGH. Yes, thanks so much, Mr. Chairman. VA's total request represents a 10 percent increase over Fiscal Year 2023 and it is comparable to Fiscal Year 2024, as you said in your opening remarks, but let me just note a couple of things. It appears at first blush that it represents a decrease in community care, but one of the biggest changes in the last several years, partly because of your generosity over the course of many years during the pandemic, is additional funding streams. One of those is unused balances from previous years.

We have been very careful to reinvest those to include in medical care. Also, under the PACT Act, you overwhelmingly give us a new authority under the TEF, the toxic exposure fund. When you consider carryover and TEF, in fact, community care grows. I think as you have seen in each of your districts, community care continues to grow at a very rapid rate.

The fact is that when you take the total picture, TEF, carryover, and the very generous request for discretionary funding, VA care grows and is sufficient to meet the challenges that we face as a health system.

It is true that across both non-defense and defense accounts in the discretionary that the budget agreement forced difficult choices. We made those difficult choices and we have put those in black and white. I am here today to defend those and to be honest with you.

After having the best hiring year in 30 years at VA last year, we are well-positioned to provide care. Having seen that this year's cap, like you guys know this better than I do, those caps it appears to me are not going anywhere, in which case the prudent thing to do is to begin to make sure that we are ready to operate in that difficult budget picture. That is what this budget does. It makes hard choices, but we put them out there for you all to see.

Last, I am going to just give you one story. I just was talking to our leadership in Texas yesterday. Our hospital Chief Executive Officer (CEO) in San Antonio had a difficult choice to make. Does she hire two Gastroenterologist (GI) docs that she has been looking for 3 years and she can now hire them because of the CSIs, because of more competitive hiring, and because docs want to come work at VA because of the ability to make decisions based on the veteran's best interests, not clearing it through Blue Cross/Blue Shield. Okay?

She made the decision to hire those two providers. That is the right decision. That is not a hiring freeze. That is a strategic choice to make sure that we have the best providers available for our vets. This budget allows that to continue and that will continue.

The CHAIRMAN. Okay. Hopefully. The next question I have got, right now not a problem that you caused, not a problem we caused, but there is another body across the rotunda that caused it. They kind of torpedoed what was the infrastructure review commissions. How are you going to maintain the health facilities and give veterans care closer to where they live and fund the community care if you cannot adjust where your footprint goes?

Mr. MCDONOUGH. Yes, thanks. Thanks for the question, Mr. Chairman. Let me just say right up front because I know that to you and to Ms. Budzinski and to others, the new facility in St. Louis, a major priority, it is—remains our major priority. We had hoped to get some funding in Fiscal Year 2024 and our budget request for Fiscal Year 2025, which was finalized before 2024 was finalized, as you look at it you get a sense that we had anticipated there would be some progress on that. Nevertheless, we anticipate there will be funding for Fiscal Year 2026 for St. Louis one and two.

We have instituted a strategy here on our infrastructure to maximize the dollars that we get, and you see that in this year's request with major investments in West LA and then across the system, significant investments in minor construction. You all raised the cap on that to $30 million which allows us to move with much greater alacrity on new outpatient clinics to get them closer to veterans. Then we are also making sure that we are prioritizing working with our interagency partners, including the U.S. Department of Defense (DOD), which I think you have all witnessed itself is reexamining very closely its balance of care between the community and the direct care system, so we are using the VA providers in DOD facilities to get that care closer to veterans.

Three good examples, Shaw Air Force Base outside Sacramento; Fort Campbell in Kentucky and Tennessee where we have a Community Based Outpatient Clinic (CBOC) open in the fort hospital on Fort Campbell; and then third at the Navy Medical Center in Pensacola, Florida, which reopened as a site for surgery, ambula-

tory surgery. We will expand that to a fuller CBOC for vets' care later this year at no expense, no additional expense to the taxpayers for that veteran care. Those are existing facilities that allows us to provide care to veterans, as I say, at no additional infrastructure cost to the taxpayers.

The CHAIRMAN. I am over on time, but I do need to figure—and so I am glad you mentioned St. Louis. I hope you are going to work—that we can get a commitment to work with you——

Mr. MCDONOUGH. You got that. You got that.

The CHAIRMAN.—on making sure that is brought back on.

Mr. MCDONOUGH. Yes.

The CHAIRMAN. There is also a quick concern that I have. We were out in the district this last week. We have seen photos in my constituents for foreclosed homes that VA manages. They are invested in—they are infested with mold, stripped of appliances, occupied by squatters.

Yesterday VA announced the Veterans Affairs Servicing Purchase (VASP) Program , which will be buying veterans default mortgages. I am very concerned about this, and I am working on legislation to give veterans a better solution. The new program will create huge increases in properties that VA will own because some will be inevitably defaulted on. How are you going to manage those right quick and then I am going to——

Mr. MCDONOUGH. Yes, Chairman, thanks very much and thanks for the heads-up about what is happening at home in your district. We will make sure—I will make sure that we specifically follow-up on those.

Fact is that our track record at VA on mortgage financing is best in industry. Foreclosures among VA mortgage holders are extraordinarily rare. Nevertheless, because of the tumult in the real estate market as a result of the pandemic, there are about 40,000 mortgage holders whose, through no fault of their own, whose mortgages are at risk.

The VASP program, building on existing authority that we have, you know, which has been over the course of the last couple of days not uniformly because I know there is critiques of it here on the committee—we take those very seriously—but have been warmly received among many veterans groups as well as the mortgage industry, underscores that this is the most cost-effective way to keep veterans in their house.

We take that very, very seriously. We think that the risk that VA takes on in the event of those 40,000 mortgages is manageable because of the safeguards we have built into the program because of what I anticipate will be your very aggressive oversight.

The costs even in extremis of any risk there are far exceeded by the potential costs and disruption for those veterans if we do not take this step for those 40,000 cases. I know that this will be an issue both throughout the rest of this hearing, Mr. Chairman, and I welcome that, but the one thing that I want to reassure you of is, you know, we are not going to be—we are going to be an open book with you on this.

We think that the oversight actually will strengthen our performance of the VASP program, but we also think it is both building

on existing authority and a reasonable investment for those 40,000 vets.

The CHAIRMAN. Thank you. I am way over on time.

Ranking Member, you were recognized.

Mr. TAKANO. Well, thank you, Mr. Chairman.

Thank you for being here, Mr. Secretary. Do you agree with my assertion in my opening statement that overall direct care is less expensive to deliver than care in the community?

Mr. MCDONOUGH. Well, like, I mean, I would say three things. One, study after study shows that the care that vets get in the direct care system leads to higher health, more improved health outcomes so better health outcomes, one.

Two, it is true that the investment that we have made over the life of VA, and look, let me just underscore again my appreciation for this committee's support and the entire Congress' support on a bipartisan basis for historic investments in VA, including throughout the pandemic, those investments mean that the unit cost per care over time because of the investment in the infrastructure to date makes VA a longer term better outcomes-based investment for the taxpayers.

Then I will say that we are witnessing a great degree of variability. This is I think a very real policy challenge for us basically at VA, but also for Congress, which is it is very difficult to run a system that is both a direct care system and functionally an insurance company. There are a lot of steps that you would take under that scenario that lead you to inefficiencies, rob you of economies of scale.

As we consider the future of VA coming out of these three monumental changes, the MISSION Act, the pandemic, and PACT Act, I think we want to get our hands around just how much risk we can take and not—I call it the cost in community care variable. That is half right. It is variable in one direction, namely up.

Then the cost of the fixed care—the fixed cost of the direct care system that makes for a very difficult challenge for us in the years ahead. I look forward to working with the Congress on that.

Mr. TAKANO. Well, so my question was pretty simple. I mean, a three-part answer. In your estimation is it——

Mr. MCDONOUGH. Yes.

Mr. TAKANO. It is less expensive to provide care——

Mr. MCDONOUGH. I believe that we do, yes.

Mr. TAKANO. You know, over the last few years VA has delivered more care and benefits than at any other time in history. I commend you and the hardworking employees at the VA for doing that and all the efforts you have gone into implementation of the PACT Act. When VA delivers it delivers well, and I think ensuring a balance between direct care and community care is more important than ever.

That said, I want to make sure I understand your 2025 budget request. First, you are proposing a transfer of $7.3 billion from the medical services or direct care account to the community care account in order to help cover the estimated obligations of $40.9 billion for community care in Fiscal Year 2025.

Second, you plan to reduce the overall number of Veterans Health Administration (VHA) employees by about 10,000 between now and the start of Fiscal Year 2025.

Third, you are also preparing to transfer $600 million to the community care account from the medical facilities account which covers things like VA facility management, renovations, and leasing, the very things that you said that it is important to invest in in order to make direct care really feasible.

You have expressed concern throughout your time as secretary about the unsustainable trajectory of community care spending and the need for VA to rebalance resources between direct care and community care. I share this concern.

I want to know how your budget reflects that. How will redirecting billions of dollars from direct care to community care and shrinking VA's workforce by 10,000 employees accomplish our shared goal of ensuring more veterans receive more of the care at VA facilities rather than in the community?

Mr. MCDONOUGH. Yes, that is a fair question. Thank you for it. Just on that 10,000 Full-time Equivalent (FTE) reduction, that is not at the beginning of the Fiscal Year 2025. That will be at the end of Fiscal Year 2025. That is what is envisioned in the budget.

This reflects the fact that not only did we have an historically strong hiring year last year, but retention is highest it is been in a long time. That is a reflection, again, of the investments that you gave us in the PACT Act and I thank you all again one more time for that.

CSI's special salary—so critical skills incentives, special salary rates, retention bonuses are paying very well because retention is up. Quit rates are down. The fact of the transfer of 7-plus billion from the direct care into the community care account is a reflection of what we have seen in the course of the last 18 months, which is a robust uptake of care in the community. Prudence dictates that we be ready for that. That is why we asked for that, that transfer.

Nevertheless, as I have said in my opening remarks, we want to make sure that partly because of the fundamental unworkability—for example, if you take Veterans Integrated Service Network (VISN) 7, which is South Carolina, Georgia, Alabama, fully 70 percent of vets in care in that system are drivetime-eligible in the first instance, meaning they qualify referral to the community by virtue of drivetime alone, even though there is no private—there are even fewer private providers available to them. When we refer them into the community they are going to travel just as far to get the care in the community.

In light of that, we want to make sure that every time we have an engagement with a veteran we make clear that the apple to the apple. If you have a referral option in the community we have a very clear offering to the veteran for how soon and where that veteran can get care in the direct care system. We think that when given that apples-to-apples comparison the veteran will choose, even when eligible for community care, to stick with us because veterans understand the positive health outcomes as well.

Mr. TAKANO. Well, Mr. Secretary, to your point of the example about the choices that the—no choices that veterans have in many rural areas that being referred into the community is not really a

solution because of the lack of providers or the nonexistence of providers.

You know, this idea that care in the community as a solution to that veteran's challenge. You know, you have made a very, kind of, I think, a very clear illustration of where the solution really is a nonsolution.

I am curious. When can we expect to see a strategy, a plan on how you are going to rebalance and how you are going to provide these veterans with true choices?

Mr. MCDONOUGH. Yes.

Mr. TAKANO. I see the response is not more community care for those rural veterans. I see that we need to stand up providers in those communities maybe in conjunction with other Federal payers.

Mr. MCDONOUGH. Yes.

Mr. TAKANO. When can we expect to see a strategy on how we are going to get our arms around this explosive rise in community care?

Mr. MCDONOUGH. You know, I think it is a fair question. I think we have pieces of that strategy are being implemented now. We have talked at length about those, but nevertheless, I think your request for kind of an all-in strategy that lays out how we will get this done is a reasonable one and we would look forward to having that conversation with you guys over the course of the next several months as you are thinking about the budget picture for Fiscal Year 2025 and beyond.

Mr. TAKANO. Well, thank you. I hope we can see that strategy soon, and I appreciate your being here. I yield back.

Mr. MCDONOUGH. Thank you.

The CHAIRMAN. Thank you.

Representative—General Bergman, you are recognized.

Mr. BERGMAN. Good morning, Mr. Secretary.

Mr. MCDONOUGH. Sir.

Mr. BERGMAN. Great to see you.

Mr. MCDONOUGH. And you.

Mr. BERGMAN. We will get right to it because time is finite. Money seems to not be in some cases but we know in the end it really is. I am on the Budget Committee this cycle and in charge of a task force on improper payments across the government.

You know, as chairman of that oversight task force is finding out, I hate to say where all the pots of money are, but how the moneys that have been appropriated out there how they are being spent. While there has been some progress in recent years can you tell me how VA, you know, continue to work to lower the improper payments to the greatest extent possible?

Mr. MCDONOUGH. Yes. Thanks very much, General, for the question. I obviously share your concern about improper payments. I am proud of the progress that we have made at VA on this. VA has reported a total reduction of $11.6 billion, which is a 79 percent reduction in improper payments over the last 5 years, and Fiscal Year 2023 is the lowest reported improper payments at VA in 9 years.

Our focus going forward is on improving our testing processes to ensure that we are getting to the root cause of any remaining improper payments and leveraging every tool available. Obviously,

that is going to be based on automation and strengthening our processes, working with the committee, and working with Government Accountability Office (GAO), with the Inspector General (IG), and with industry to prevent improper payments on the front end.

I will just give you one example. This is in our education programming. One of the routines, it is slightly different from the improper payments basket, but one of the places where we had been accumulating or veterans had been accumulating unknowingly debt is education overpayments because they had stopped going to class.

We have instituted a process of regular text exchange with student veterans to make sure that they are still where they had planned to be so that they are not incurring debt accidentally. That is the kind of testing and automation that we want to make sure that we are making progress on.

Mr. BERGMAN. Okay, thank you. Different subject——

Mr. MCDONOUGH. Yes.

Mr. BERGMAN [continuing]. psychedelics, as you—I am the co-chair of the Psychedelic-Assisted Therapies Caucus——

Mr. MCDONOUGH. Yes.

Mr. BERGMAN [continuing]. along with Lou Correa from California. I was happy to see the VA issue a request for applications for studies into 3,4-Methylenedioxymethamphetamine (MDMA)-assisted therapy to treat Post-Traumatic Stress Disorder (PTSD) in veterans, and I am glad the budget listed these treatments as priorities.

However, given the reduced funding for research and reduced healthcare workforce under the budget, how will VA prioritize research into psychedelic-assisted therapies and the most critically probably, the training of the therapists in these new regimens to administer the treatment so that veterans can actually, you know, get their results and, you know, as U.S. Food and Drug Administration (FDA) approval moves forward?

Mr. MCDONOUGH. Yes. Well, thanks very much for the question and thank you for your support of this new tool. Partly by listing it the way we do in the budget and mindful of what appears to be fairly rapid progress from FDA, although it is obviously difficult to see inside FDA, but also because of the great hope that we hear from many veterans including here in Congress about these treatments, we feel duty-bound to prioritize this so that we are ready when FDA gives a green light so that vets do not rush into this without the support of VA because there is going to be risk if there is not supportive of VA. The funding levels that you talked about, the staffing levels will not impact our prioritization of this.

Last point I will make, Mr. Bergman, is I do, however, anticipate debate about this up here just judging by the reaction to our budget proposal. One thing that I think I just want to dogear is I anticipate that over the course of the next several months as you all work through and the appropriators work through our budget I would anticipate seeing some back and forth, maybe even some effort to limit our ability to invest in these new tools in the course of this this budget cycle.

I just—I put that out there something that we should make sure that we are working together on. Yes.

Mr. BERGMAN. Thank you. I see my time is running short, but I just wanted to say if you remember a couple of years ago before the football game we had our picture taken with Brittany Elliott?

Mr. MCDONOUGH. I do. How could I forget?

Mr. BERGMAN. Yes, with the exoskeleton, and it has been moving forward. I guess there is more money into it and I would guess I would implore you and every—the VA has lagged on getting these devices that are proven to the veterans who need them. With that I yield back.

Mr. MCDONOUGH. I will just say I do not want to drag this out, Chairman, I just want to say I met last week with an amazing soldier, a triple amputee from his service in Afghanistan. I first met him at Walter Reed many years ago. I used to work in different roles in the U.S. Government.

His experience in both managing his prosthetics but also the support that he has gotten, for example, adaptive technologies for driving, left me with the impression that there is work for us to do across the board on this. We are instituting a journey map, a review of the veteran experience on this. We will make sure that we include Brittany in that and we will make sure that we are doing right by these brave men and women.

The CHAIRMAN. Representative Brownley.

Ms. BROWNLEY. Thank you. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here. Thank you for highlighting vet centers and the trauma that too many of our women veterans experience in their service to our country. Vet centers are such an important footprint within the VA infrastructure, so I really appreciate you mentioning both of those.

I have a couple of questions and if you could be as brief as possible——

Mr. MCDONOUGH. Sure.

Ms. BROWNLEY [continuing]. because I would like to get them all in.

Mr. MCDONOUGH. Yes.

Ms. BROWNLEY. The first is on childcare and I noticed that the budget requests $18.6 million for childcare. Can you give me some idea of the progress that you are making to ensure that every VA Medical Center has access to childcare options as was promised in the Deborah Sampson bill?

Mr. MCDONOUGH. Yes. Well, thank you very much. We are obviously—we are taking this very seriously. Obviously, the pandemic challenged us in that regard, but we see two paths to make this happen. One is direct to veteran reimbursement for the care that that veteran invests to facilitate his or her appointment. The second is making sure that there is—the second prong is making sure that there are sites on campus.

We think the two sites closest ready to go are Fresno and Shreveport. There are two questions here is how quickly can we get the regulatory process done? The appropriators have warned us about that being slow to an order places on campus to open up, so we are looking now at whether there is some regulatory guidance meaning something more quick we can do to get those sites stood up to partner along with places like Seattle where we have deployed other pilots.

Our promise in the Deborah Sampson Act I think is by Fiscal Year 2026. We will keep pushing on this very aggressively. I cannot make a definitive promise that we will make Fiscal Year 2026 at every VA facility, but there will be good progress on this one.

Ms. BROWNLEY. Thank you. We should also try, you know, try to put at least one to test it in a big, urban, I think in a big, urban center in a medical center.

Mr. MCDONOUGH. Fair enough.

Ms. BROWNLEY. Yes. In terms of VA spending on our women veterans, it seems to me that it is difficult really to determine whether the budget allocated for gender-specific care is proportional to the growing rate of utilization of women and other gender-specific care. Do you have the data to compare these metrics over a 5-year period, over a 10-year period?

Mr. MCDONOUGH. You know, what I can tell you is that we have doubled the funding in the last 10 years, but I cannot—let me take that and then give you that and maybe lay that against the demographic or actuarial data to show you how we are making the investments.

We do use the model, what we call the middleman model, to inform our decisions on gender-specific care and to inform our decisions on the office of woman's health which oversees the WISE grants, which is also the basis by which we hire gender-specific providers and deploy gender-specific technology like mammography.

I think that is a fair question. Let us get that to you in writing.

Ms. BROWNLEY. That would be great because it is really hard without the data to really understand if we are, you know, the budgets that are being proposed are adequate enough based—you know, we need that proportionality.

Mr. MCDONOUGH. I think that is a fair question.

Ms. BROWNLEY. Great. Great, great, great.

Mr. MCDONOUGH. That is a good question.

Ms. BROWNLEY. I also notice that, you know, in the budget that you are seeking a 20 percent increase in the caregiver support program and also I think for long-term support services you are asking for $17.9 million, which I think is about an $800 million increase. I guess my question is if we were to pass and put into law the Elizabeth Dole bill would you eventually see the cost of those two programs diminish over time?

Mr. MCDONOUGH. That is a good question. In the interest of time let me just say two things. One, let me take that and get that back to you in writing because I had not considered that, but two, the investments that are in there are a reflection of what we anticipate of turning back on the expanded caregiver program, which we will do over the course of this fiscal year—sorry, next Fiscal Year into 2025.

Let me make sure that I understand specifically the impact of your bill on the long-term cost of that program and I will get that back to you.

Ms. BROWNLEY. Thank you very much, and I yield back.

The CHAIRMAN. Representative Rosendale.

Mr. ROSENDALE. Thank you, Mr. Chair.

Good morning, Secretary.

Mr. MCDONOUGH. Good morning.

Mr. ROSENDALE. Always good to see you again.

Mr. MCDONOUGH. And you. And you.

Mr. ROSENDALE. Let us start off, thank you very much for your help in Montana. We are making a lot of progress to improving the healthcare delivery for the veterans there, and I am looking forward to having a permanent director, which I understand is very soon——

Mr. MCDONOUGH. Yes, in the works.

Mr. ROSENDALE [continuing]. to make sure that we get Fort Harrison straight.

Secretary, in January an opinion article in The Hill was written by three VA psychologists with over 40 years of clinical experience and it was titled, "The VA is abandoning women veterans' rights for gender identity'." The article pointed out that, "Single sex spaces within the VA, those ensuring bodily privacy such as bathrooms, exam rooms, and medical exam areas can now be accessed by males who self-identify as women."

Now, we have just made an incredible investment in the VA facilities across the Nation because of the growing population of females within the veterans' community and so I really do not understand so that we were making all this investment to try and make them feel comfortable, to make them feel more welcomed into the veterans' facilities why we would now be opening these exact same facilities to males who are identifying as women?

Are you aware of a letter that I wrote about this topic with Representative Crane back on February the 12th?

Mr. MCDONOUGH. I am aware of your letter. I would have to refresh my memory if I have responded to you yet, but I know that we are working that. I also know that when I saw the report in the newspaper I also reached out to VHA to make sure that they were talking to our clinicians across the system.

You know, our commitment to all of our vets is that they get care in a safe environment, that they feel safe, and I have every expectation. In fact, it is my conviction that we ensure that for veterans.

Mr. ROSENDALE. We are not just talking now about the veterans and their level of comfort to make sure that our female veterans can come into these facilities and feel inviting, okay, and feel safe about it, but the article was published. One of the psychologists' direct reports delivered a memorandum removing her from her role as a psychologist. A psychologist was pulled away from her patients for approximately 1 week after being reinstated. There is no question that this resulted in disruption of care for her patients.

One of the other psychologists who wrote the article was kicked out of the VA chat and was previously prevented from supervising students for his opposition to Diversity, Equity, and Inclusion (DEI) initiatives.

You said at a press conference when asked about the article, "We do not require our employees to choose between their conscience and their career."

Mr. MCDONOUGH. We do not.

Mr. ROSENDALE. That is the case 365–24–7. That is a noble goal. However, these employees did speak their conscience and they were punished. There seems to be a little bit of a disconnect be-

tween the words and what has happened to these employees. Are you aware of the retribution that these employees have faced?

Mr. MCDONOUGH. What I understand is that it is standard VA practice that when, you know, there is a dust-up around a provider that the local leadership would take a look at what the dust-up is about and then they would make some decisions about. That is, as I understand of what happened in this case, as your question suggested, the veteran—sorry—the provider went back to patient care within a week. You said there is no question that had an impact on the veterans' care. I actually have not seen any sense that there is a question whether it impacted veterans' care, meaning I have seen no evidence that it did impact veterans' care.

Those kinds of procedures which are laid out in VHA practice guidebooks across the system are the kinds of steps that I would think a responsive, high reliability organization would take.

Mr. ROSENDALE. The employees should not, in your words, "be subject to retribution for speaking their conscience."

Mr. MCDONOUGH. I do not think this is retribution, Congressman. Like, again, this is all derivative. I am learning this partly to make sure that I can respond to you and Mr. Crane. These are decisions—these are potential processes laid out in VHA guidebooks about how to make sure that we are managing the provision of care effectively across the system. I do not think this is retribution.

There was questions about the dust-up. It sounds to me like the local leadership looked into it and within a week the person was back on the job.

As to the employee-controlled chat group, you know, I mean, I am not going to—I do not think it is appropriate for me to start managing who is members and who is not members of a chat group. You know, I think those are collegial decisions that our professionals can——

Mr. ROSENDALE. Well, I will take you at your word because——

Mr. MCDONOUGH. Yes.

Mr. ROSENDALE [continuing]. we always have been able to rely on each other and it has always been also my experience that when you are made aware of these things——

Mr. MCDONOUGH. Yes.

Mr. ROSENDALE [continuing]. that you have looked into them and made sure that they were made straight.

The last comment that I would just like to make is that while Ranking Member Takano embraces the expansion of the VA, what our job here is to make sure that the veterans get the care that they have earned, that they deserve, when they want it where they want it, not to protect the VA. It is not to protect the VA. It is to make sure that the veterans get the care that they have earned and that they deserve when they want it where they want it.

I assure you when you are dealing in urban areas it is a lot easier for the veterans to slip into a VA facility than it is in Montana where we have 100,000 veterans that are dispersed across 145,000 square miles and they are heavily dependent on the community care in order to make sure that they are being taken care of.

Thank you very much. I appreciate——

Mr. MCDONOUGH. Thank you.

Mr. ROSENDALE [continuing]. I appreciate all your work.

Mr. MCDONOUGH. Thank you and I appreciate your always being available to me and, you know, look, I think Montana is emblematic of the challenge that we face in this country, which is access in rural settings. I have spent time in many of your districts asking these same questions.

I suggest that among organizations making investments in rural settings few rival the amount of dollars that VA itself is investing in rural settings, and I think that is important. Part of that is based on our belief that rural veterans deserve access to the highest quality care, too, right?

This is also why we are working with DOD and even now with U.S. Department of Agriculture to make sure that we have high quality care sites available to veterans across 140,000 miles——

Mr. ROSENDALE. 145,000 square miles.

Mr. MCDONOUGH [continuing]. 145,000, yes. It is a little bigger than Minnesota but not that much.

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

The CHAIRMAN. Representative Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Mr. Secretary, great to see you. Thank you for your continued hard work——

Mr. MCDONOUGH. Thank you.

Mr. LEVIN [continuing]. on behalf of our veterans and your team as well. We appreciate you and thanks for visiting so many of our districts.

Mr. MCDONOUGH. You are right to thank them. They do all the work, not me.

Mr. LEVIN. Absolutely. Absolutely. Thank you for always being available visiting so many of our districts. You are always welcome——

Mr. MCDONOUGH. Thank you.

Mr. LEVIN [continuing]. in our district. I wanted to get through a few questions. First, I want to bring something up that I have discussed in our budget hearings for the past 2 years and that is the veteran and spouse transitional assistance grant program. I was proud to authorize the program as part of Isakson and Roe to support local organizations that provide coordinated transition assistance services, such as resume assistance, interview training, and job recruitment training to veterans and their spouses.

VA issued a proposed rule for implementation of this program in July 2023 and last month Congress appropriated $5 million to begin awarding grants. Now that VA has the funding in hand when do you expect to open the grant application?

Mr. MCDONOUGH. Well, we are working through the comments that we have received now, and so I have to be careful about that, but we are working through those comments and we will publish a final rule when we are done there. Then we will be in a position to begin administering the grants, you know, pursuant to well-established, publicly commented on rules so that everybody gets a fair shot at it.

Mr. LEVIN. Thank you for that. VA estimated that full program implementation would cost $26.3 million per year, but the Fiscal

Year 2025 budget request maintains level funding for $5 million and with the program only authorized for 5 years VA has limited time to scale it up, make the case for long-term authorization.

I have the same question for you that I did last year, hoping for a clear answer. When does VA plan to fully fund the program?

Mr. MCDONOUGH. When we can prove that we have the right programmatic setup to ensure that it is successful. I think we want to, you know, build to that through experience and through proven performance rather than—which is something that we do all too often, buy the dream and then find out that we cannot execute the full dream. We end up complicating outcomes for veterans and not being the best stewards of taxpayers' dollars along the way. We will build to it. I cannot give you a firm number on that but this is why it is so important that we get——

Mr. LEVIN. Along those lines, Mr. Secretary, will you commit to moving as expeditiously as you can——

Mr. MCDONOUGH. You have that. You have that——

Mr. LEVIN [continuing]. so that I do not have to ask the same question next year?

Mr. MCDONOUGH. Yes.

Mr. LEVIN. Excellent, thank you. Wanted to move on to a local issue for me, the Jennifer Moreno VA Medical Center in San Diego, who has been trying to purchase land from the University of California, San Diego since Fiscal Year 2020. VA has not included this request and its short-term budget year requests.

When VA facilities have to wait years for Congress and VA to allocate funding for a land acquisition project and the cost of land continues to increase, we end up unnecessarily wasting taxpayer money. In both last year and this year's budget request you asked for Congress to pass legislation allowing VA to allocate funding for land acquisition projects without specific congressional authorization.

The final Fiscal Year 2024 appropriations bill included language that removed the requirement for VA to get specific authorization from Congress on VHA land acquisition projects, but it did not amend the underlying statute or allocate any funding for VHA land acquisition projects.

Do you still need authorizing language in a separate appropriations line item to make the VHA land acquisition line item a reality?

Mr. MCDONOUGH. We do.

Mr. LEVIN. I look forward to working with my colleagues on this committee to get the authorization enacted into law so we can get the resources to VA facilities as quickly as we can.

Last, Mr. Secretary, I want to thank you for your steadfast commitment to ending veteran homelessness. Your budget includes $3.21 billion for this purpose with increases for most programs, except supportive services for veteran families, SSVF, which would receive a decrease. SSVF, I believe, is the heart of VA's homelessness prevention efforts and has grown in recent years to fill critical needs, but can you discuss the rationale behind the funding decrease for SSVF?

Yes. You know, this year's funding level really draws on what we learned last year which is that we have an increase in unsheltered

homelessness. This is why grant per diem is really so important, but also why we are investing as much as we are investing in prevention this year.

We are trying to get ahead of the challenge by keeping more veterans in their homes, hence the things like the VASP program, but also trying to make sure that because we saw last year for the first time in a number of years, I think 3 years, an increase in 7 percent of veteran homelessness, which included unsheltered veteran homelessness.

That is what is reflected in the budget.

Mr. LEVIN. I am out of time. Again, I want to say thank you for the hard work that you and your team——

Mr. MCDONOUGH. Thank you.

Mr. LEVIN [continuing]. are doing and I look forward to further discussions soon. I yield back.

The CHAIRMAN. Representative Van Orden.

Mr. VAN ORDEN. Thank you, Mr. Chairman.

Mr. Secretary, April 21, 2023, the Veterans Administration put something on their website and I want to ask you if these things became true. With our budget we are discussing that Veterans Administration said that there would be 30 million fewer veteran outpatient visits that take place?

Mr. MCDONOUGH. No. We had a net increase.

Mr. VAN ORDEN. That we undermined access to telehealth. Did that take place?

Mr. MCDONOUGH. No.

Mr. VAN ORDEN. Or wait times worsen for benefits because you are going to be forced to eliminate 6,000 staff members?

Mr. MCDONOUGH. Again, we gained——

Mr. VAN ORDEN. An estimated 134,000 claims?

Mr. MCDONOUGH. We are resolving claims 17 days faster this year than last year.

Mr. VAN ORDEN. Were you prevented from construction of VA healthcare facilities that veterans needed?

Mr. MCDONOUGH. No.

Mr. VAN ORDEN. No. Did you fail to honor the memories of all our veterans by eliminating approximately 500 staff that take care of our cemeteries?

Mr. MCDONOUGH. I did not. We did not.

Mr. VAN ORDEN. It did not happen? Okay. Did you cut housing for veterans? I do not think you did because we just talked about that. Did food security increase for veterans—insecurity?

Mr. MCDONOUGH. No, it did not.

Mr. VAN ORDEN. It did not. Okay. Deprive veterans of mental health substance use healthcare services, did that happen? That did not happen either, did it? Okay. Did you eliminate job training? Did not do that either.

When the ranking member of this committee says that the VA will end as we know it if Donald Trump is elected, do you think that that is true?

Mr. MCDONOUGH. You know, I am not going to get——

Mr. VAN ORDEN. I do not like politicizing this either, sir, but I am telling you I am not standing for this stuff. There are article after article after article about how Donald Trump increased the

ability for veterans to get care. This stuff that you put on your website and that these people echoed on the other side of this chamber, you just said on the record did not take place.

We are not going to fearmonger here with our veterans. I know you do not do it. You did it here. We talked about this. You came to our office. There is absolutely no place for this in this committee at all.

I believe that Mr. Takano should publicly apologize for this. Donald Trump will not be destroying the Veterans Administration as we know it when he is elected as President. Okay. I did not plan on doing that, but I am not going to stand by and listen to this political garbage in this committee at all.

Okay. VASP, sir, you said in your letter you sent it over here last night about 8 that you think that the VASP thing is going to turn out well for veterans. Can you envision a world where the Veterans Administration is going to force veterans to leave their homes? Will the Veterans Administration foreclose on a veteran and make them homeless?

Mr. MCDONOUGH. No.

Mr. VAN ORDEN. Okay. Here is the problem, sir. If the Veterans Administration assumes these loans, puts them on their books, first of all, the amount of work that has been done on this is wholly inadequate even from the staffing amount of folks that you think you are going to have to hire to administer about $15 billion worth of loans. Veterans may or may not be able to pay these loans back and they are going to be on the VA books.

You just told me that you are not going to evict a veteran from a home which means that the Veterans Administration is going to be paying the mortgage of a home for a veteran which means the government of the United States of America is going to essentially make these public buildings because we are paying for it. You are going to have a private citizen living in a public building. They tried that before in the Soviet Union and it did not work.

The issue that we have here—no one on this committee, Mr. Levin is my ranking member who I respect tremendously, cares about veterans homelessness as do I. This is not the way to do this.

The Veterans Administration has the potential to destroy the second best thing the Veterans Administration has ever done. The first thing is the GI Bill that fundamentally created the middle class. The second one is the veterans home loan guarantee. By you guys doing this in a very unthoughtful manner I am afraid that you are going to wreck that program and we cannot have that.

That is how I bought my home. I want our young veterans to be able to buy homes with that program and because there has been a nearly complete lack of thought put into this and there has been, go through it in a different form, I do not want to extend this conversation. I believe that you are going to do much more harm than good and it is unintentional.

I would like, again, to follow-up. We had a meeting with the chairman and your undersecretary on this but we have got to get down to brass tacks on this because I am unwilling to be the chairman of the subcommittee that is responsible for destroying the veteran home loan guarantee.

Thank you for your time, sir.

Mr. MCDONOUGH. Thank you.
Mr. VAN ORDEN. Yes. It is good to see you.
Mr. MCDONOUGH. And you.
Mr. VAN ORDEN. With that, I yield back, Mr. Chairman.
The CHAIRMAN. Representative Pappas.
Mr. PAPPAS. Thank you, Mr. Chairman.
Mr. Secretary, good morning——
Mr. MCDONOUGH. Good morning.
Mr. PAPPAS [continuing]. and I appreciate your thoughts here today, particularly as they pertain to community care and that is what I intended to ask about. I do not want to be repetitive here, but this is an issue that we think a lot about in New Hampshire.

We know that we have got a lot of rural communities that are underserved. Community care clearly has helped close important gaps but we also want to make sure that it does not supplant VA healthcare, which is a concern that I hear directly from our medical center leadership.

They have made great strides at improving services at the Manchester VA, recently opening a wellness center. They have got a women's health clinic that is under construction, but they are expressing concerns that they could be unable to further expand services at the facility and make it an attractive option for veterans if we are going to continue to see the community care budget increase. This is in a State where everyone is automatically eligible for community care.

Can you talk about that balance as it pertains to the Manchester VA and how we can work with leadership there to make sure they can continue to bolster services and show veterans the advantage that they provide in terms of seeking care within that facility?

Mr. MCDONOUGH. Yes. Well, I thank you very much for that question and I appreciate the conversations we have had about this. I think a challenge for us as a country is to ensure that there is greater access in rural communities to healthcare, and this is a major challenge in every one of your states, a particular challenge in yours. It is a particular challenge for VA because veterans are more likely than non-veterans to come from rural communities and to return to rural communities.

The challenge for us is making sure that we can get that care closer to veterans and that we do not think that making a referral into the community is the end of our relationship with a veteran because, (a), we have to coordinate that care, make sure that it is fit into all the other care that the veteran is getting, but we also have to make sure that we are not just referring the vet into the community and then he ends up driving 3 hours to see somebody in the private sector anyway when they might be able to go a much shorter distance to come to a VA facility, even if that VA facility is outside the 30-or 60-minute drivetime window.

That is what we are trying to do. We are also trying to make and take advantage of things like VA Health Connect. All of us have access. Well, I will just say myself, I have access to Blue Cross/Blue Shield. I can get a nurse practitioner on the phone to triage concern about my kids or my family or myself. We now through VA Health Connect have concluded 45 million calls last year. These would not be included in clinical encounters we had talked about

earlier. That gets a vet in touch with a nurse practitioner to resolve that veteran's question obviating the need to travel.

That is the kind of use of telehealth, the kind of use of triage available options that we are trying to test to ensure that we do not boil this down to just say, hey, you have qualified for travel time. Here is your referral over. You go take care of this.

Mr. PAPPAS. Sure, and I am wondering if you can address concerns that some of the VSOs have in their testimony about the infrastructure spend in Fiscal Year 2025? The request is 33 percent lower than last year.

Some concerns also around State home construction grant programs funding, VA requested $30 million less than Fiscal Year 2024 levels, which we know is woefully short of where we need to be to fund priority projects, especially as we think about the number of veterans that are in long-term care in these facilities.

Can you talk about specifically the State home construction grant program and——

Mr. MCDONOUGH. Right.

Mr. PAPPAS [continuing]. that that level that you requested?

Yes. Look, as I said in my opening, in the opening set of questions, the caps did force difficult decisions on the Federal Government. I think that is, well, it is as it is.

This is one of those cases where we made that decision. We are examining different funding streams, as I said, cooperation with other Federal agencies. Last year we attempted to try to get mandatory funding for this to make sure that we can invest at the levels and rates we need to.

When your average facility in terms of hospitals, I do not have to remind you of this, is 62 years old, the major construction account is not going to be made whole each year at, you know, $2 billion. We have to figure out a different way to do that.

We are testing options. I really appreciate the VSOs pushing on this because we have to figure out how we get around a difficult set of caps, especially when we have the dynamic on costs that we have been talking about throughout the course of the year.

Mr. PAPPAS. Yes. Thank you for your comments there. It is a huge issue. We have got a significant backlog. We have got to address it.

Mr. MCDONOUGH. Thank you.

Mr. PAPPAS. I yield back.

The CHAIRMAN. Representative Luttrell.

Mr. LUTTRELL. Thank you, Mr. Chairman.

Mr. MCDONOUGH. Sir.

Mr. LUTTRELL. Good to see you as always, sir.

Mr. MCDONOUGH. And you.

Mr. LUTTRELL. Thank you for all the hard work and please pass the word to all the undersecretaries and everybody that comes in front of the Disability Assistance Subcommittee. I am not always easy on them, but they are doing an amazing job.

I heard you state the previous year's numbers and the growth rate in employees and the successes that we have or are having in the VA, which I am over the moon about, but there is one number that grew last year that you and I spoke about that should not be

growing. That is your number one issue from what I understand at the VA and that is suicide.

Mr. MCDONOUGH. Yes.

Mr. LUTTRELL. That is something we have yet to corral. As a neuroscientist studying the brain and emotional behaviors for the past 15 years now, I think, I want to solve this problem. This should not be a conversation that we are having. You and I every time we have a meeting together this is the number one topic that we talked about.

I heard the general speak about the progression of alternative medications in space in alternative to the opioid problems that we have, the Selective Serotonin Reuptake Inhibitors (SSRI)——

Mr. MCDONOUGH. Yes, sir.

Mr. LUTTRELL [continuing]. and the existing modalities that we are utilizing for these problem sets. That, you know, if you roll the clock back a decade the numbers are—they are sustained. We are not doing what we need to be doing.

Mr. MCDONOUGH. Right.

Mr. LUTTRELL. We need to fix that problem. It saddens, it sickens me to sit here in the House of Representatives and say that, hey, we have this problem. We have to fix it, but we say this every year.

Mr. MCDONOUGH. Every year.

Mr. LUTTRELL. I want the VA to be the leading edge of the sword. You have that capability. If there is legislation that is not in place that allows the VA to be where all the other institutes of higher learning and research come running to the VA to say you are leading the way how can we help you or can we learn from you, that is what I want to see.

That transcends the research space down into our veteran community where we do not have this problem set. With the budget line, I mean, I can throw numbers at this all day long. What are we going to do? How are we going to fix this problem?

I know you cannot answer that question because it exists. It is such a wide net that we have to cast, but no more. I mean, what was it, over 6,000 deaths last year? What are we doing? How are we going to fix this problem, sir? I mean, with this budget line are we moving money in the proper direction to centrally focus on this issue?

Mr. MCDONOUGH. Yes. Well, I think that we have got to, as you are suggesting, I think we have got to get the solutions closer to the veterans' communities and closer to the veteran. I think what you see in this budget is enhanced efforts at outreach to try to get veterans into our care, enhanced investments in the people and organizations who know their vets best.

You know——

Mr. LUTTRELL. If it is community care or primary direct primary care at the VA that is——

Mr. MCDONOUGH. That but also investing in local organizations who know vets.

Mr. LUTTRELL. Yes, absolutely.

Mr. MCDONOUGH. So——

Mr. LUTTRELL. We have to be, and I hate to say this, sir, because I would never put myself in your position, but we have to be

hyperaggressive on this. I mean in an uncomfortable momentum——

Mr. MCDONOUGH. Yes. No, look I mean, we have got to be, like, hyperaggressive about it because we have to act like a life depends on it because it turns out more than 6,000 do depend on it.

This is the whole idea is to get the care, the awareness, the investments closer to the veteran, closer to the people who know the veterans most to ensure that when a veteran stops showing up, when a veteran is isolated there is support, (a), people know that there is support for people who know that to do something about it.

Then there is availability of mental health treatment so that when the veteran reaches a moment when he will come out of isolation and get the care that he does not have to wait to get the care, that he gets the care. You know, we are trying to push that as close to the veteran as we can.

Mr. LUTTRELL. I would like to see the expansiveness of this, of not only this dollar amount but the research mechanism inside the VA——

Mr. MCDONOUGH. Yes.

Mr. LUTTRELL [continuing]. go out into deeper waters, deep brain stimulations. We are seeing research that says, hey, that addresses addiction and emotional instability.

Mr. MCDONOUGH. Yes.

Mr. LUTTRELL. You know? I am going to close with my last 20 seconds. I do not know if I heard you correctly but did you say there is going to be problems on this side as far as moving appropriations to research with the psychedelic medications?

Mr. MCDONOUGH. I am just reading back to you the mem cons that I got out of our briefing about our budget. I think we were surprised that we got a little pushback. I cannot remember from whom we got that pressure——

Mr. LUTTRELL. I can assure you I will be digging into that because not only just the veterans in this community that you see now, but there is a high majority of the congressional Members that they do not want this problem to exist any longer. I think with the research and the experiences that the veterans have had to share with the body I think we can put that——

Mr. MCDONOUGH. You have had——

Mr. LUTTRELL [continuing]. hopefully put that to bed.

Mr. MCDONOUGH. You have made the sale. You have underscored to me the impact of this, and the more I scratch at it, as I told you, I am skeptical.

Mr. LUTTRELL. Yes, sir. I understand.

Mr. MCDONOUGH. The more I scratch at it the more—and the more I hear from our providers the more determined we are to make sure that we do the right thing.

Mr. LUTTRELL. Thank you, Mr. Secretary. I appreciate it.

Mr. Chairman, I yield back.

The CHAIRMAN. Representative Cherfilus-McCormick.

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chair.

Mr. Secretary, the Fiscal Year 2025 request indicates a 44 percent cut to the IT modernization account. The budget seems to be focused on maintaining legacy systems over modernizing them.

There are several modernization efforts already in progress. How do you intend to fund those programs under this budget?

Mr. MCDONOUGH. Yes. This is, you know, among the challenges in the budget. This is one. As I said, the caps and the fact that we are no longer operating in the pandemic era of very, very generous appropriations which, again, I thank everyone on the committee, Republicans and Democrats for those investments.

This is a maintenance budget. I will just be very candid with you. As we briefed it out we have made that clear to your teams as well. That is true in IT.

We have got to make sure that we are maintaining the progress we have made. We do have incremental funding so that we can maintain momentum on modernization projects like Financial Management Business Transformation (FMBT), for example. Obviously, we will stay on top of those but, you know, the budget does force some tough choices and IT is one of those places.

Ms. CHERFILUS-MCCORMICK. You said it is a maintenance budget but right now when we look at the Electronic Health Record Modernization (EHRM) budget, which was cut in half, I understand that it is related to the program's current status under reset. However, the dramatic budget cut in this program leaves me concern that there are no real plans to move from reset to implementation.

Mr. MCDONOUGH. Yes.

Ms. CHERFILUS-MCCORMICK. Do you expect EHRM to resume any go-lives in Fiscal Year 2025?

Mr. MCDONOUGH. Yes. Well, here is what I would say. We are not staying in reset forever. We are going to get into deployment one, two. Why? This is really, really, really important and we are committed to making it happen. We need a single health record across the VA system, and we need one that talks more effectively to DOD.

The fact is that when we get to the, well, during the course of this year as we approach the end of the year I anticipate us being in discussions to get out of reset. When we get there remember that we have, and this is one of the things that the chairman talked about, we have carryover. We have prior year funding. It is 3-year funding available to us to deploy in the first instance beyond the reset.

We have existing money that would not that be accounted for, prior year appropriated money not accounted for in this year's request that is slated and available for us when we exit reset.

Ms. CHERFILUS-MCCORMICK. Just for clarification purposes——

Mr. MCDONOUGH. Yes.

Ms. CHERFILUS-MCCORMICK [continuing]. do you plan on being in reset for the entirety of Fiscal Year 2025 or not?

Mr. MCDONOUGH. We do not.

Ms. CHERFILUS-MCCORMICK. How do you plan on specifically funding the go-lives if we are having this——

Mr. MCDONOUGH. With the 3-year funding that is existing already. We have that at VA already so we have prior authorized—prior appropriated money available to us to deploy when we get out of reset.

Ms. CHERFILUS-MCCORMICK. Okay. The budget request also indicates a 65 percent cut in the infrastructure readiness program that

is focused on addressing VA's massive technical debt. Given that most of VA's work relies on the department's aging IT infrastructure, this is a huge disservice to VA employees and veterans. How can we expect to expand access to care and benefits for veterans on IT systems and equipment that are growing older and more obsolete every day?

Mr. MCDONOUGH. Well, this is why, for example, TEF is so important. TEF allows us, and look, we have been very, very careful with the TEF. The law that you all passed said any incremental funding for the treatment of toxic exposure over the Fiscal Year 2021 baseline can be TEF.

We have been very careful about this. We have briefed your teams at length about it. We have methodologies for each of our components, including IT, Office of Information and Technology (OI&T), and we are going to be in a position to make sure that because of that TEF money we can continue to make progress, including on important infrastructure improvements like benefit delivery.

Moreover, some of our infrastructure was bought ahead during, for example, EHRM deployment. We are getting sites deployment ready so we are in a position to continue, as I said, maintain momentum, continue momentum, maybe not at the level we would have anticipated in a place where I forget who said that, I guess General Bergman said that sometimes money seems infinite. We get that it is not.

We think it is prudent to make the decisions that we are making, and we think that we have a plan to make that happen.

Ms. CHERFILUS-MCCORMICK. Well, one more thing I wanted to ask you because it seems like with all the cuts you are really relying on the excess of the supplemental funds that you had from TEF and other sources. Now, do you have any concerns that you might run short because it seems like in all these cut areas that you are planning on supplementing it there? Is there enough to supplement the entire budget because we see so much extensive cuts?

Mr. MCDONOUGH. Yes. You know, I think I would disagree with the characterization of extensive cuts. I think we have been trying, you know, as I said, you were very generous to us throughout the pandemic. You know, we have been planning carefully, carefully planning the use of those funds so those carryovers those are incorporated into the budget laid out in front of you. We are in a position to use those.

Am I worried that, you know, we are going to have to, you know, for example, the chairman mentioned that there is no second bite in the budget. We do not anticipate one but if we need one we will come back and talk to you guys about it then.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

The CHAIRMAN. Thank you. It is the chair's intent to recognize Representatives Self for his 5 minutes and then we will go break and go into recess for the Ambassador's speech. Return please as quickly as possible after the speech.

Representative Self.

Mr. SELF. Thank you, Mr. Chairman.

Mr. Secretary, good to see you.

Mr. MCDONOUGH. Sir.

Mr. SELF. I have heard several comments in this hearing that community care is more expensive. According to your budget, and this was quickly done, you are asking for 52 million outpatient visits at community care for $37 billion.

You are also expecting 89 million outpatient visits with VHA for $83 billion.

Now, this indicates that community care is not more expensive so we probably ought to refine our figures and our comments along those lines. Do you have a sense of the ratio of your 10,000 personnel cuts through attrition? What will be the ratio of bureaucracy versus frontline providers? Do you have a sense?

Mr. MCDONOUGH. I think I could probably get you a more detailed sense of that. I think we just did a deep dive with your staffs last week, but we have, obviously, prioritized hiring frontline providers, frontline workers. I think, throughout the course of the pandemic we did, for example, because we did make a decision to protect the most vulnerable veterans in our care.

We did make a decision in individual facilities to move more care into the community so that requires a different kind of hire in those pandemic years 2020, 2021, for example, than we would normally be making.

I would anticipate that in this year of strategic hiring we are focusing overwhelmingly in the hires on providers.

Mr. SELF. I would ask you that through your attrition what is the ratio of your loss, however you want to structure that, because I want to focus——

Mr. MCDONOUGH. We will get you——

Mr. SELF [continuing]. exactly as you just said. We need to be focused on our providers.

Mr. MCDONOUGH. Yes.

Mr. SELF. If we take the attrition cuts it needs to be in the bureaucracy.

Now, in the latest the budget that was passed, the one we are in now——

Mr. MCDONOUGH. Yes.

Mr. SELF [continuing]. I understand that now it is very clear that you are not to report veterans who have a fiduciary to the National Instant Criminal Background Check System (NICS) data base. Is that correct and have you changed your policies to make sure that does not happen? That we are giving the constitutional protections to our veterans simply because they have a fiduciary?

Mr. MCDONOUGH. Let me answer that question by what we did because I am not sure I understand about changing the policies.

Mr. SELF. Well, in the past you have, because you read the law differently than most people, other Federal agencies, that if you have a fiduciary for a veteran you would then put them in the NICS data base. That was your policy in the past, and I think that is forbidden under the latest budget and I want to make sure that your policies follow the law.

Mr. MCDONOUGH. Yes. We turned off, or I think it is a monthly or bimonthly reporting mechanism, to the Department of Justice. We turned that off when Congress enacted the rider on the appropriations bill. We are not reporting any fiduciaries, any new fiduciaries to the Department of Justice at the moment nor, inciden-

tally, since that reporting is now turned off can we take any veterans no longer on the fiduciaries who had been reported to Justice off.

The reporting is turned off.

Mr. SELF. Does that apply to your advance budget for 2025, I guess, as well?

Mr. MCDONOUGH. It is an appropriations bill rider, so as with all appropriations bill riders it will expire at the end of the fiscal year.

Mr. SELF. That was my question. I am afraid that is the case.

I also, and I am almost out of time, I would like for you to look at the training videos that you are using in VA today. They are produced by someone that is associated with Planned Parenthood, and I am very concerned that they promote abortion as the safest option for pregnant veterans.

I find that a little oxymoron in aspect, but I would ask——

Mr. MCDONOUGH. I would think that that would—I would have a hard time believing that is true.

Mr. SELF. Well, absolutely.

Mr. MCDONOUGH. I will find out.

Mr. SELF. I would ask for a report on that because if this is true, and apparently it is, I would like to know about it.

Mr. MCDONOUGH. Fair enough.

Mr. SELF. With that, I yield back, Mr. Chairman.

The CHAIRMAN. The gentleman yields back.

The committee will stand in recess until the end of the Ambassador's speech. Hopefully, like I said, everybody can get back.

Mr. Secretary, thank you for staying.

Mr. MCDONOUGH. Yes, of course, of course. Thank you very much.

[Recess.]

The CHAIRMAN. The committee will come back to order. At this time we are going to continue with questions. Representative Deluzio, you would have 5 minutes to ask your questions.

Mr. DELUZIO. Mr. Chairman, thank you.

Secretary, good to see you. Thanks for your patience as we welcomed the Japanese Prime Minister today. I will be blunt. I am a little worried about this budget. I think it is driving a trend toward privatization that I am alarmed by.

Since the VA MISSION Act was implemented we have seen fee-for-service, excuse me, community care go from accounting for a relatively limited portion of the VHA's budget intended to help improve veterans' access to care when direct care from VA was not convenient, was not nearby, did not make sense to now what I think is a ballooning program that now accounts for more than a third of all spending on veterans' health care with worse outcomes in many respects.

That community care has been siphoning funds from what I think is already an underfunded Veterans Health Administration. The trends show that that sign or those signs are not going to be changing anytime soon.

Since 2020, the financial obligations for medical community care has grown about twice the rate of VA direct care, and yet we already know that community care is more expensive, its quality on many measures has been worse, patient outcomes in many places

have been worse, care coordination is worse, oversight is more limited. Let us talk as an example about emergency room care.

A study found veterans treated in private Emergency Rooms (ER) twice as likely to die in the first 28 days after admission that they have been admitted to a VA facility. If veterans had an ambulance transport them to the VA emergency department their prospect of dying in the subsequent months was 46 percent lower than if they had gone to a non-VA facility.

Now, let us talk about opioids. Last September the Office of Inspector General (OIG) released a report about the stunning lack of oversight of private non-VA providers who prescribe opioids to veterans outside the VA. Found that about 80 percent of those non-VA providers who prescribed opioids in veterans in Fiscal Year 2021 did not complete VA's training module nor certify they received and reviewed the guidelines put in place under the MISSION Act.

Their sample of those community providers show that about two-thirds did not check the State data bases that are meant to monitor against over prescriptions and abuse.

Stock wait times, we do not have, frankly, wait time data. Veterans cannot look up what a wait time will be in community care, but based on most of the studies wait times are shorter in VA care and getting better. The same is not happening in the community.

Training, VHA does not require the same training it does of VA providers or folks in the community and only a small share of those private providers complete the training.

I think we are at a tipping point. I think this privatization trend is not fiscally responsible. I do not think it is good for veterans.

Just this week I received notice that the Pittsburgh VA in my district effective immediately is implementing a hiring freeze and why? The explanation given so they can deal with rising costs of fee-for-service community care. I see the direct connection and it worries me. I know Pittsburgh VA is probably not alone in this.

I think, Mr. Secretary, this budget is doing much of the same to encourage these trends that I worry about. More than $20 billion has already been appropriated to fee-for-service community care for 2025. Community care has already received $9.8 billion from the cost of war toxic exposure fund, as I understand it.

This budget proposes siphoning around $7.3 billion from VA direct care to fee-for-service community care. Do I have the basic numbers right, Mr. Secretary?

Mr. MCDONOUGH. You do.

Mr. DELUZIO. Okay.

Mr. MCDONOUGH. Yes, you do.

Mr. DELUZIO. I know you agree we need to curb the spending issue here. One way I think VA could easily do that would be to update access standards so that telehealth counts. In other words, VA today I cannot point to the availability of a telehealth appointment when thinking about whether someone you refer to the community and yet that same veteran might find themselves receiving a telehealth appointment.

My question, Mr. Secretary, do you plan to change those access standards, and if so, what is that timeline looking like? I know we have talked before about this.

Mr. MCDONOUGH. Yes. Mr. Deluzio, thank you very much. We are looking at the access standards. We are looking expressly at the telehealth access standard. We have talked to your teams about this, House and Senate.

We do think that it is not helpful to veterans to give them a referral and then they just end up seeing a doctor in telehealth outside the VA system, so we think that does not make a lot of sense. We are looking at that. I cannot give you a specific timeline on that regulation but we are working it.

Then we have two other parts of our—two other additions to our strategy over and above what I talked about before, which is the apple-to-apple offer of in-house care every time a veteran is referred out. We have dramatically increased access through our access sprints. We saw 25,000 new patients, more new patients in VA clinics October to February. That is an 11 percent increase.

We saw that increase in 81 percent of our facilities, including Pittsburgh. That means 14 percent fewer veterans had to wait to get into the community. They got directly into VA. We did that through offering evening clinics, weekend clinics, additional access to telehealth. We are going to continue to do that.

All of that requires us to maintain strategic hiring. That is why we had the good hiring year we had last year and that is why the strategic hiring will continue.

Last, in your visit, I think Pittsburgh and the rest of that system does a very good job at using telehealth authorities across the State to get access to things like tele-oncology. Let me just say one thing about tele-emergency care. We have now rolled this out in 25,000 individual instances across VA have. Far this year 15,000, 10,000 cases last year.

The median case has us meet the veteran's medical needs within 30 minutes never leaving his home, meaning he does not have to drive, he does not have to risk infection, he does not have risk hassles of going to an emergency department, a VA emergency department or a private sector emergency department.

Things like that, VA Health Connect, tele-emergency care, and enhanced access, as we have just demonstrated in the last 5 months of the access sprints, means that we will make sure that a veteran has timely access to the best available care, namely the VA system, whenever and with clear understanding of what those parameters for each offering will be.

Mr. DELUZIO. Mr. Secretary, thank you.

Mr. Chairman, I thank you for indulging on the time. I appreciate the apples-to-apples work. I think it is very important, Mr. Secretary.

Mr. MCDONOUGH. Thank you.

The CHAIRMAN. Dr. Miller-Meeks.

Ms. MILLER-MEEKS. Well, thank you very much. It is wonderful to see you again, Secretary McDonough. Thank you, Chairman Bost, for holding this hearing.

Let me just say that I am a veteran. I am a doctor. I delivered community care and I had excellent outcomes, thank you very much, despite having tremendous hurdles getting the VA to approve of community care.

Secretary McDonough, have no difficulties with tele-emergency care. We actually had that discussion yesterday in Energy and Commerce, or access standards. I want to know, number one, of care that is delivered in the community how much of it is specialty care and how much of it is primary care?

Mr. MCDONOUGH. It is overwhelmingly specialty care.

Ms. MILLER-MEEKS. Thank you. That would make a difference in the cost regardless of whether that care was provided at the VA specialty care is higher than it is generalized primary care, is it not?

Mr. MCDONOUGH. Yes. Well, cost is a function both of the care provided but then also what we call the standard episodes of care provided.

Ms. MILLER-MEEKS. And——

Mr. MCDONOUGH. What we find is that the access standards or the standards as prescribed now for many years include a suite of standard episodes of care that lead to what appears to be redundant care, what appears to be maybe prescribing techniques, like Mr. Deluzio said. This is not uniformly the case. I am just saying these are some of the things that we see that contribute in the IG's findings, anyway, contribute to——

Ms. MILLER-MEEKS. Do you have severity data on patients that are either admitted to the hospital or come to the ER, i.e., to your point, are we comparing apples-to-apples?

Mr. MCDONOUGH. Severity data in what sense? I am sorry.

Ms. MILLER-MEEKS. In individuals who go to the emergency room or are admitted to the hospital what severity, medical severity are they? If you do not have that data if you could get that data to us? That is——

Mr. MCDONOUGH. Sure. I do not have it at my fingertips, but yes.

Ms. MILLER-MEEKS. Thank you. I understand the VA is setting up a red team to write a report on reducing community care spending, but the report has not been shared with this committee. Who are the members of this red team, who appointed them, and what are they recommending?

Mr. MCDONOUGH. Thanks for your question. The red team is, and this is, kind of, standard analytic tool designed to answer questions about what has happened with community care over the course of the last 6 years since the new law was signed into statute. I gather they have finished their report. I have not seen it. They have submitted it to VHA.

The members of the committee include former undersecretaries of health in Republican and then Democratic administrations, as well as public health and medical experts. I do not have the names in front of me because I am, frankly, not intimately familiar with the report yet, although I will get there.

Ms. MILLER-MEEKS. Is any veteran forced to go into community care?

Mr. MCDONOUGH. Is what?

Ms. MILLER-MEEKS. Is any veteran forced to go into community care?

Mr. MCDONOUGH. You know, it is an interesting question. You talk to veterans and some of them feel that they have been and so——

Ms. MILLER-MEEKS. Why would that be? Specifically the MISSION Act is within 30 days or so many miles, so if a veteran can get into an appointment within 30 days at the VA——

Mr. MCDONOUGH. Within 20 for special—for primary care visits.

Ms. MILLER-MEEKS. Then they have no need to seek community care——

Mr. MCDONOUGH. Right.

Ms. MILLER-MEEKS [continuing]. is my point. A veteran is not forced to go into community care. I, however, know veterans who would prefer to go into community care.

Mr. MCDONOUGH. Yes, ma'am.

Ms. MILLER-MEEKS. Building new clinics to get access when you have hospitals or other facilities that are in deplorable condition, I would say, would question one's priorities.

A question on homelessness that was asked, Department of Housing and Urban Development Veterans Affairs Supportive Housing (HUD VASH) is an important program to permanently house veterans' homelessness, and I applaud the VA's work to house over 48,000 vets last year. However, I think there are still some challenges that we have. Do you know how many vouchers are made available on an annual basis?

Mr. MCDONOUGH. I do not have the voucher number on my fingertips.

Ms. MILLER-MEEKS. Okay. Do you know how many vouchers are unused on an annual basis?

Mr. MCDONOUGH. We have that. We can get you that data by VISN, but we have that data. We set execution standards every year and we report those to you guys as well.

Ms. MILLER-MEEKS. Okay. My understanding is that many of the HUD VASH vouchers go unused year after year, so why are we still increasing the overall budget for this program?

Mr. MCDONOUGH. That is true that some HUD VASH vouchers go unused. We have identified a range of reasons why that is. Sometimes that the value of the voucher is insufficient given the price in a particular market. Some of it has to do with our slowness in appointing or hiring case managers, which are really important to organize——

Ms. MILLER-MEEKS. Well, maybe instead of letting 10,000 healthcare providers go and increasing the number of bureaucrats, as was alluded to earlier, maybe that is a part of our budget we could rethink.

With that, I yield back.

Mr. MCDONOUGH. Just for the record, our proposal is not to reduce clinical providers and then increase bureaucrat. Though I just want to go back to one thing about how veterans feel. You know, the Veteran Signal is something that we have instituted now for 10 years. It is a really important tool.

You know, what we do find is that, I hear it anecdotally, we see it in some of the data that veterans feel that they have been forced into the community. I am not saying that they have. I am saying that they feel that.

This is why it is so important to us to communicate to every veteran very clearly apple-to-apple what their opportunities are. We feel like when they are in our care they do better. That is what study after study says.

The CHAIRMAN. Dr. Miller-Meeks, do you want to reclaim time?

Ms. MILLER-MEEKS. I am going to reclaim my time. Thank you for that. When I met with veterans, and I am in the veteran community a lot as a fellow veteran, they love the care they receive at the VA hospital. They do not like waiting periods.

They also appreciate the care they receive in the community and they want choice and they want flexibility. Thank you.

Mr. MCDONOUGH. Yes.

The CHAIRMAN. Representative Budzinski.

Ms. BUDZINSKI. Thank you, Chairman Bost and Ranking Member Deluzio.

Secretary, it is great to see you.

Mr. MCDONOUGH. It is good to see you.

Ms. BUDZINSKI. Thank you for all the work you and your team do at the VA every day for our veterans.

Mr. MCDONOUGH. Thank you.

Ms. BUDZINSKI. It is very appreciated. I wanted to talk a little bit about research that the VA is doing. I very much believe that that worked at the VA is doing in the research fields is critically important to understanding illnesses and mental health. Its research breakthroughs have huge impacts on not only our veteran populations but on the general population as well.

I am glad to see that the VA's research priorities largely reflect the needs of the veteran population, but I am concerned that the actual funding request does not meet the urgency for research on these topics.

Additionally, the latest VA veteran suicide prevention report noted an increase in veteran suicide and specifically that that rate has increased dramatically for women veterans in particular. I am wondering how the VA is ensuring the budget request is taking into account the specific needs of our women veterans.

My question is, Secretary McDonough, in that vein is can you speak to why the Fiscal Year 2025 budget request includes flat funding for suicide prevention efforts and decreases funding for our VA priority areas like the million veterans program, precision oncology, or VA Office of Research and Development (ORD) infrastructure and Traumatic Brain Injury (TBI) and brain health research in particular?

Mr. MCDONOUGH. Yes. Well, thanks very much. You know, as I said earlier that obviously we make tough choices in the budget and that is a function of the caps. That is also a function of being now in this period post-pandemic where we just do not have the very, very generous budgets that we had gotten from you all over the previous several years.

Nevertheless, the research budget does allow us to continue funding for priority research efforts. The million veteran program is, obviously, a very big priority for us. It is also a very significant security priority for us by the way. Ability to access that data base is not solely dependent on VA funding.

Important innovations that will come out of that data base are not uniquely connected to our funding. We have researchers who can bid to use that data and that means that prior year robust investments in tools like that mean that very innovative research can continue in the out years notwithstanding, for example, when we reduce investments in that.

As it relates to women's health and woman's health research in particular, all of our research decisions are made by the veteran experience and by what veterans therefore are experiencing. Our budget does allow both based on existing funding it does allow us to continue advancements and particular focuses for women veterans.

It is true that if we could do more we would obviously welcome that opportunity, but we think that these are important investments.

Ms. BUDZINSKI. Is the VA able to, you know, assuming that these funding levels stay where you have requested, is there, kind of, preparation that the VA can be doing to take into account just to make sure that these programs continue to optimally operate and coordinate with VSOs in particular for their feedback on how to, kind of, work with the VA on these types of funding levels?

Mr. MCDONOUGH. Absolutely, definitely.

Ms. BUDZINSKI. Yes.

Mr. MCDONOUGH. Definitely.

Ms. BUDZINSKI. Great. I wanted to ask about another question as well, another important note. Chairman Bost and I share some VA facilities, and I want to ensure that our rural veterans are getting the care that they need, something that I have taken a specific interest in on this committee.

One of those facilities I wanted to ask you about is the VA Hospital in St. Louis. What are some of the ways the VA is exploring optimizing rural healthcare initiatives and infrastructure projects, given the budget constraints for VA facilities like the St. Louis VA, which serve large numbers of rural and women veterans?

Mr. MCDONOUGH. Yes. Well, thanks so much. You know, for the last couple of years that I have been here the Office of Rural Health has been flat funded, but it is been flat funded for a really important reason which is, first and foremost, it is one of the principal funders for the clinical resource hubs and for the rural health centers of excellence or the rural health resource centers.

There is five of those and that funding allows us to then make sure that we can expand the capability of VAMCs like St. Louis to reach farther into rural communities through telehealth and through innovations.

The second thing that the Office of Rural Health allows us to do is invest in new modalities of the provision of care in rural settings. Home-based primary care is a good example of this. Telehealthcare over the course of the last 10 years or so was underwritten by the Office of Rural Health.

Those things get incubated by the Office of Rural Health but then get deployed into the field and therefore funded by the medical care account itself.

Last, as it relates to rural facilities we are more and more deploying through programs like Closer to Me, which is a oncology

treatment and infusion care program, allows us to deploy providers from somewhere like St. Louis into a CBOC in a more rural setting in southern Illinois or central Illinois and have a veteran get their oncology treatment at the CBOC rather than driving all the way to St. Louis.

It reduces the demand or the challenge of travel for that veteran, allows the veteran maybe then to have family with them as they are getting that infusion, and it means that the veteran does not also have to go into the private sector which may not have treatment options any closer than that CBOC. These kinds of efforts to promote access and to promote ease of access are a big part of our strategy going forward.

Ms. BUDZINSKI. That is great. Thank you, Secretary.

I yield back. Thank you.

Mr. MCDONOUGH. Thanks.

The CHAIRMAN. Mr. Secretary, thank you for your time——

Mr. MCDONOUGH. Thank you.

The CHAIRMAN.—and waiting around with this situation that we had today. I do need to address one more important matter before you leave.

Mr. MCDONOUGH. Please.

The CHAIRMAN. Over the past year VA has been more than a month late in responding to over a dozen letters. Currently, VA owes this committee responses to numerous letters, including on important issues like improper benefit payments, abortion, and employee misconduct at VA medical centers.

Further, when VA finally responded to committee letters the response is often inadequate. Your repeated failure to provide sufficient answers to my Office Of Resolution Management, Diversity, and Inclusion (ORMDI) letter last fall led to the committee's first subpoena in 8 years. Most recently, in your 2-month—you are 2 months late on a response to a letter seeking documents related to VA's attorney's anti-Semitic comments, and we have not been given any of the documents that we were asking for.

I do want to ask if we can get your commitment for those documents that I asked for and the letter that was in January 20, that we had sent on January 25th? If we could try to get those by next Friday if at all possible?

Mr. MCDONOUGH. Okay. I will turn to this as soon as they get back to the office.

The CHAIRMAN. Thank you so much for being here and thank you for, as I said, waiting around when we do not—you know we do not normally do this.

Mr. MCDONOUGH. No, no, thanks very much for the opportunity to testify.

The CHAIRMAN. Thank you. We would like to welcome the next panel up.

All right. I would like to welcome our second panel. Thank you for hanging around for the length of time you did, and we appreciate it.

Representing the independent budget service organizations from the Veterans of Foreign Wars we have Mr. Patrick Murray, the director of national legislative services.

We also have Mr. Shane Liermann, the deputy national legislative director of Disabled American Veterans.

Finally, we have Mr. Butler, the senior health policy advisor at Paralyzed Veterans of America.

I ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

The CHAIRMAN. Thank you, and let the record reflect that all witnesses answered in the affirmative.

Mr. Murray I now recognize you recognize you for 5 minutes for any opening remarks.

STATEMENT OF PATRICK MURRAY

Mr. MURRAY. Thank you, Chairman Bost, Ranking Member Deluzio and members of the committee. On behalf of the independent budget VSOs, DAV, PVA and VFW, thank you for the opportunity to present our recommendations to properly fund the Department of Veterans Affairs.

For more than 30 years, the IB VSOs have provided independent recommendations to ensure that VA remains fully funded and capable of carrying out all of its missions. I would ask for the record our complete independent budget document will provide an overview of our most significant recommendations.

First, it is important to note that VA's full-year appropriations was not enacted until half the year had passed. This routine use of continuing resolutions limits VA's ability to expand access to critical benefits and services for veterans. We believe Congress must do better.

Mr. Chairman, with veterans continuing to roll and receive higher priority eligibility due to PACT Act, the IB VSOs recommend that VHA be provided a total of $152.8 billion for Fiscal Year 2025, which would be a 6.6 percent increase from the previous year.

Underlying all of VA's healthcare delivery is its infrastructure, the buildings in which it provides care and services. We are concerned that VA's request for major and minor construction is one-third lower than what VA requested last year and that is far below what is necessary.

We recognize the critical importance of having modern up-to-date facilities which is why the IB VSOs recommend $5.2 billion alone for major construction which is four times more than the current funding level and almost $1 billion for minor construction, which would be a 30 percent increase.

Infrastructure funding has remained stagnant for far too long. In the past 10 years it has only increased 5 percent. During that same time, the construction backlog known as the strategic capital infrastructure, sorry, strategic capital investment plan, known as a SCIP, has grown exponentially. In 2014, the SCIP was approximately $16 billion worth of work. Right now it is estimated to be $130 billion. That is an increase of 116 percent. Funding cannot remain stagnant.

Private healthcare invests considerably more into the infrastructure of their networks. Last Congress, Kaiser Permanente testified before the Senate Veterans Committee that they invest approximately 3 percent of their overall budget into its infrastructure. VA invests considerably less, only close to 1 percent. Unless there is

drastic increase in resources for VA infrastructure we will continue to see additional gaps in the backlog versus work that is able to be performed each year.

Infrastructure costs have gone up year-over-year and it will not get any less expensive over time. This will also force more care into the community and exacerbate hiring challenges for VA.

Mr. Chairman, generally the administration's budget request takes a positive step toward fulfilling our Nation's obligations to America's veterans. In fact, with the exception of a few items, like the aforementioned infrastructure issue, VA budget meets or comes close to many of our recommendations. However, we do have concerns about funding trends in the VA's budget.

Over the past decade VA's reliance on community care has risen drastically. While we agree that veterans must have non-VA options to fill gaps in care, we believe VA must remain the primary provider and coordinator of veterans' care. While VA is requesting an overall increase for medical care, the community care program would grow at a faster rate than VA-provided care.

In addition, VA's request would cut 10,000 healthcare FTE including 600 physicians, 2,400 nurses, 500 nonphysician providers, and over 2,000 healthcare technicians despite VA reporting more than 66,000 healthcare vacancies at the start of this year. We should not be cutting positions when we cannot even fill the ones we currently have.

We are also concerned that VA proposes using $12.7 billion in carryover funding rather than requesting new discretionary appropriations. If VA's unobligated balance at the end of Fiscal Year 2024 is less than projected we are concerned about a potential funding shortfall next year.

Last, we believe that the greatest roadblock to properly funding veterans' benefits and services comes from budgetary enforcement mechanisms designed to limit Federal funding. To ensure our Nation meets its sacred obligations to America's veterans, the IB VSOs call on Congress to exempt veterans' programs, services, and benefits from congressional Pay As You Go (PAYGO), as well as work to eliminate the use of CRs for VA care.

Mr. Chairman, this concludes our testimony. My DAV and PVA colleagues and I will be pleased to answer any questions you or members of the committee may have.

[THE PREPARED STATEMENT OF PATRICK MURRAY, SHANE LIERMANN AND ROSCOE BUTLER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Murray. The written statements of all three witnesses will be entered into the record. We will now proceed to questions.

Mr. Murray, I spoke earlier about the VA attorney who made the terrible anti-Semitic comments. VA Office of General Counsel is requesting a significant budget increase. What is your view of how VA has handled the situation with this attorney and what do you think the office's priorities should be in dealing with this?

Mr. MURRAY. You know, obviously anything anti-Semitic is terrible. That needs to be flatly stated. Office of General Counsel needs a lot of resources. They are under resourced right now. They are still working in paper-based systems. They are understaffed.

In fact, there is a lot of discussion about the claim agents and nonaccredited folks, but they are not even, we believe, enforcing the laws for the actual accredited people right now, the rules and laws that they have already have. For example, there are accredited attorneys who are violating the law and all they are doing is receiving demand letters telling them to stop.

They can do a better job. We do not believe they are prioritizing that. We hope more people and more resources will take care of that so that accredited attorneys and agents who are already breaking existing laws are held to account.

The CHAIRMAN. Okay. My next question is going to be real difficult for each one of you to answer, but I know in your job you are going to say nothing, probably, but let me ask you anyway. Mr. Murray, and all three of you, the VA budget is approaching $400 billion. What wasteful and ineffective programs would you cut? How and why would you do that?

I know that is not really, like I said, within your, you know, but we are trying to know that everything that we are doing is efficient and truly helping the veterans. When an agency is the second largest bureaucracy in the world it is in there somewhere.

Mr. MURRAY. Sure. There are ways to be more efficient with your spending. I do not know necessarily about cutting, but if we spend more money appropriately we will save money in the long term, for example, paper-based systems. That takes a lot of manhours. That takes a lot of resources. We need to modernize it. It has an upfront cost to some of those things, much like the Electronic Health Record (EHR) does, but also infrastructure.

If we spend appropriately now it is going to save us less—more money in the future. Having to eliminate wasteful repairs, maintenance, things like that on old systems just to keep them limping along instead of spending the proper money to build efficient, modern systems.

It is not necessarily a cut but it is a better way to spend the money we do have.

Mr. LIERMANN. Thank you so much for the question. Along with what Mr. Murray just said, I do not have a recommendation on a program that cut but an idea for us to be more efficient, specifically when we are talking about toxic exposures and presumptive diseases.

We all know the PACT Act was monumental and will continue to be, but we also know it came with a very large cost. That is because we decided to wait 20, 30, 40 years before we take action on establishing presumptive diseases.

There is a way we can do it faster, do it quicker. If we can establish things up front we are not going to wait 20 or 30 years with such a larger cost to do something. DAV and Military Officers Association of America (MOAA) we are going to be putting out a report and a study coming out in July to talk about all of these conditions and our recommendations on how to make this presumptive disease process work more efficient for veterans, the VA, and when it comes to spending.

Mr. BUTLER. I do not have a recommendation either, but I believe the OIG has identified numerous opportunities for cost savings with regard to waste, fraud, and abuse, and VA has not lived

up to those recommendations. I would recommend that Congress hold VA accountable in regard to the OIG report as it regards to waste, fraud, and abuse, and ensure that they take corrective actions to eliminate those that are wasting money due to fraud and abuse.

The CHAIRMAN. Thank you. You know, I am going to continue down this path because I have to believe, and we are monitoring this, and matter of fact, Mr. Self is himself has jumped into it as well, that when we are looking at many of the programs we are wanting to do after the PACT Act, many of our bills were wanting to move.

Somewhere, sometime there has to have been some program that was passed that has either been ineffective or wore out its effectiveness of possible treatments, programs, or whatever. I know, like I said, you want to see the expansion but we want to see that to make sure that the things that we are investing in are those that do what they were promised to do when we passed the legislation, whether it was while we have been here or those that came before us to try to straighten it out. Any suggestions you might have at a later time I might——

Mr. MURRAY. Mr. Chairman, if you look at some programs that were obviously well-intentioned at the time with the VRRAP program, the Veteran Rapid Retraining Assistance program, right, that was built up for COVID putting people back to work post or during COVID, things like that were well-intentioned. Did not exactly pan out.

If we look at things like the GI Bill restoration that was part of the Forever GI Bill there was a lot of money that was set aside for that. It did not live up to the numbers that we thought it might have.

There are ways to look at things we have done over the years where we might have overestimated or gone, you know, worked off of Congressional Budget Office (CBO) scores that may not have been——

The CHAIRMAN. Right.

Mr. MURRAY [continuing]. totally accurate over time. Blue Water Navy is another example. There were massive estimations about who that is going to help, how many people. It was not nearly as much.

There are places to look at that. We would more than happy to chat with you and——

The CHAIRMAN. All right. I would appreciate that help.

Representative Deluzio.

Mr. DELUZIO. Thank you, Mr. Chairman, and echo your good concern about public expects us to give the best bang for the buck of taking care of our fellow veterans. Never be shy please with ways that VA can do better.

Gentleman, the independent budget recommended $36.8 billion in overall funding for fee-for-service community care for Fiscal Year 2025. It turns out to be about $4 billion less than what VA itself is expecting to obligate for that care next fiscal year.

What are your thoughts about VA's proposal to transfer 7-plus billion from direct care medical services account to the fee-for-service community care account in Fiscal Year 2025? Relatedly, do you

have concerns about the effect this will have or may have on VA medical facilities and VA's ability to provide direct care to veterans?

Mr. MURRAY. Mr. Deluzio, we do have concerns about that. As you mentioned some of the statistics in your statement, it is some of the trends that we are looking at. That is why making VA care as the primary provider of care the first thing we think is important because of all the success metrics we have seen, but we cannot do that without the people to provide the care and the up-to-date, safe buildings to do that in.

That is why to the chairman's point about fraud, waste and abuse we think we want to focus more on efficiency. I we get those things done in place, that there is a place to do that, we think that is going to save money in the long run.

Mr. DELUZIO. Very good. Anyone else on the panel if you feel free?

Mr. BUTLER. I will just say the staffing reductions that VA is talking about reducing staffing, they would not have to reduce staffing if they can find ways to lessen community care out in the community. They should not be reducing staffing. They should be building its staffing levels to ensure that institutional care or VA care they have the resources to provide that care to our Nation's veterans.

Mr. DELUZIO. Thank you. Just real quick, we are always concerned about VA is not the primary care provider. Is there going to be a good coordination of that care, especially when we started talking about medications and what they refer to as polypharmacy?

A lot of veterans can get multiple medications from multiple sources within VA or in the community care and nobody is watching what that negative synergistic effect is going to have on their care.

That is why we really believe VA being the primary care provider and coordinating it is the best interest for veterans.

Mr. DELUZIO. Well, I appreciate that point on care coordination in particular. We have had some oversight about that and I have asked questions of it is very inconsistent and very sporadic what providers outside of VA are doing in terms of getting records back into VA, what veterans can see about their care.

Certainly VA can do better and we are going to push VA to better on care coordination, but it seems like the Wild West. Some providers I am sure do well. Seems like others do not, and so I appreciate that point.

With what little time I have left, transitional housing, so those providers are routinely contacting this committee to discuss resources they need to serve aging veterans or those with disabilities and their care. Would H.R. 491, the Return Home to Housing Act, provide more resources for Grants and Per Diem (GPD) providers? What kind of resources do those providers need to better be able to serve the aging and disabled homeless population?

Mr. MURRAY. Mr. Deluzio, passing the Home Act would go a great way in accomplishing that mission. GPD payments we believe they need to be upheld to the rate that they are in that bill. It does cost a lot to accomplish that mission so putting that bill forward, getting that done in the veterans' package I know that is being

threatened to be dropped for months, but we want that to come to fruition.

Mr. DELUZIO. Very good. Gentlemen, thank you.

Mr. Chairman, I yield back.

The CHAIRMAN. Representative Ciscomani. Easy for me to say this late in the day.

Mr. CISCOMANI. Thank you, Mr. Chair. I appreciate the opportunity and thank you so much for being here with us today.

My first question here is for Mr. Liermann. Thank you. The VA budget proposes to cut VR&E staff, and as I have been talking about and hearing a bit, I introduced legislation this week, the Vets Opportunity Act, which would expand the educational opportunities available to veterans and skilled trade programs. Do you perceive there to be an issue with the VR&E cuts and then the staff cuts and the VA's ability to connect our most-deserving veterans with career and education opportunities?

Mr. LIERMANN. Absolutely. Over the last year, and thank you for the question, there was a 40 percent increase in applications for VR&E and a lot of that is because of the PACT Act more veterans are eligible. Any change to that is going to have a negative impact on veterans trying to complete their programs.

Any way that we can find that will assist them in transitioning and, most importantly, overcoming their own service-connected disabilities to find gainful employment is where we should always be focused.

Mr. CISCOMANI. Thank you. Thank you. Maybe you know this, I represent the southeastern part of Arizona. This is over 70,000 veterans are in my district and one military base and one military installation, Davis-Monthan (D-M) Air Force Base and Fort Huachuca. Especially in the Cochise County area where Fort Huachuca is, the veteran population is a strong and big percentage of the population there. This is very important to my constituents so I want to make sure that those services are there and available.

Now, Mr. Murray, it is a goal of mine to ensure that veterans have the option to receive care conveniently as close to home if they have the ability. We have heard from veterans in my district, as well as some VA staff, that there is confusion among veterans when it comes to their community care appointments. Specifically, they are sometimes unsure who their points of contact are scheduling appointments and follow-ups, especially in light of the VA's proposal to cut community care by, quite frankly, an astounding $10 billion.

Do you have suggestions on how the VA can better be allocating resources to go toward outreach and education to veterans regarding the utilization of community care?

I gave Cochise County as an example. This is one of the main areas where I hear this from, more on the outside of rural areas where there is confusion when they have to travel to get care. This is, again, very important to my district. Would you mind commenting on that?

Mr. MURRAY. Absolutely, sir. I have experienced it myself personally. Some members of my family have experienced some of the confusion about coordinating community care. I think that, you know, picking up the phone and having to call around and speak

to the right person, get transferred, wait on hold, speak to the right person——

Mr. CISCOMANI. Yes, exactly.

Mr. MURRAY [continuing]. it is very difficult. We can do better with technology. I know that apps might not be the most preferred thing for a lot of folks, but it will help streamline things if we get things online, appointments, the ability to track and schedule, things like that so you can see that in real time right from your phone.

We can get better at informing our veterans about their care and their appointments, what is available, and then also places for them to follow-up so there is not spending the better part of a morning on the phone waiting on hold.

Mr. CISCOMANI. Yes, and I do agree that, obviously, technology is always going to be more cost effective and we want our Federal agencies and departments to be conscious of those expenses to be put in the right place. At the same time I do not think any effort is too big to be able to reach our veterans as well. Some would prefer the app or technology. Some will prefer, depending on their comfort level, to speak to a person.

I understand the staffing challenges on that, but I also appreciate the priority placed on making sure that every veteran is met where they are, both in their comfort level on communication, but many times physically as well in making sure that we have these resources and services where they live without having to go to great extent to travel and get there.

Even more so when they already do not have the services locally but it is hard to get a hold of someone that makes it even more difficult. I have had cases where just a simple question—this was not for care to go visit someone but the preface of a question they had to travel to feeling that they had a better shot at someone hearing them if they were there in person.

I do not like to hear that. I do not think any of us like to hear that. I just challenge you to address this issue as well and make sure that we meet veterans where they are both physically but also in their comfort level to communicate.

Mr. MURRAY. Completely agree.

Mr. CISCOMANI. Thank you, sir.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you. I want to say a thank you again for staying around and had the day drawn out like it did, but I am dealing with these issues. We are and I am very concerned that the VA seems to be struggling to manage its budget.

Congress has also provided the resources VA requested and I am committed to prioritizing our veterans. That is from our Republican side of the aisle regardless of what might have been said in opening comments and you all know that. I believe both Republicans and Democrats are trying to do the best that we can to make this budget work for those people who have served us so well.

The budget gimmicks that the VA is using are becoming more and more complicated, and I think they are seeing some of it backfire on them. VA is the only organization I know of where a 10 percent budget increase can result in a shortfall. Does not happen in your house. I just do not see it, but it does not add up.

I want to assure you and the veterans and VA employees watching this hearing that we will continue to work with the department to straighten this mess out. We are going to preserve the health care and benefits that veterans depend on and the other services that VA provides. We are going to make sure that employees are treated fairly.

I think we can best accomplish that by simplifying the budget. With that, I ask unanimous consent that all members shall have 5 legislative days in which to revise and extend their remarks and include any extraneous material. Hearing no objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 12:50 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESSES

Prepared Statement of Denis McDonough

Chairman Bost, Ranking Member Takano, and distinguished Members of the Committee, thank you for the opportunity to testify today in support of the President's Fiscal Year 2025 Budget and Fiscal Year 2026 Advance Appropriations (AA) Request for VA.

VA is honored to serve the Nation's heroes—our Veterans. Over the last 3 years, we have delivered more care and more benefits to more Veterans than at any other time in our Nation's history. VA is working to provide Veterans, their families, caregivers, and survivors the best care in the world, the benefits they have earned, and a dignified last resting place that honors their service and sacrifice. Last year, Veterans submitted over 2.4 million claims—a record, and 39 percent more than in 2022. Veterans also submitted nearly 2.3 million intents-to-file—another record, and 65 percent more than in 2022. In Fiscal Year 2023 alone, the Veterans Benefits Administration (VBA) completed more than 1.9 million disability compensation and pension claims, breaking the previous year's record by nearly 16 percent. VA delivered a record $163 billion in earned benefits to over 6 million Veterans and survivors—and provided more in-person, tele-health, and telephone appointments than ever before. The Board of Veterans' Appeals processed over 103,000 appeals, more than in any previous year. Additionally, more than 46,000 Veterans were permanently housed, far surpassing the Department's goal of 38,000. And more than 4.1 million Veterans of every war and conflict, now rest in VA national cemeteries.

The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (P.L. 117–168) represents the largest expansion of Veterans' benefits in a generation, and I am immensely proud that our broad efforts have yielded outstanding results as we continue to see steady increases in the number of toxic exposure-related disability compensation claims processed. VA just recently fully implemented section 103 of the PACT Act, ahead of schedule, which expanded health care eligibility to all Veterans who were exposed to toxins and other hazards while serving our country at home or abroad and all Veterans who served in the Vietnam War, the Gulf War, Iraq, Afghanistan, or any combat zone after September 11, 2001, or were deployed in support of the Global War on Terror. Nonetheless, we can do more to ensure that every eligible Veteran receives the benefits and health care they have earned. Our focus remains on increasing Veteran outreach, timely and accurately processing of claims, providing more and better-quality health care, modernizing our information technology (IT) systems, and ensuring that we have the necessary staffing with the right skills to deliver on our promise to Veterans.

FY 2025 Budget and Fiscal Year 2026 AA Request

VA's total 2025 request is $369.3 billion (mandatory and discretionary, including collections and the Recurring Expenses Transformational Fund (RETF)), which is a $32.9 billion or 9.8 percent increase above the 2024 level. This includes a discretionary budget request of $134.0 billion (with $4.4 billion from medical care collections and $307 million from RETF), an $8.9 billion, or 6.2 percent, decrease from 2024. The 2025 mandatory funding request is $235.3 billion, with $24.5 billion from the Toxic Exposures Fund (TEF), an increase of $41.8 billion, or 21.6 percent, above 2024.

The decrease in discretionary funding of $8.9 billion from 2024 reflects the Fiscal Responsibility Act of 2023 (P.L. 118–5), which set overall non-Defense discretionary budgetary ceilings. Nevertheless, we project that the 2025 request will provide the necessary resources to meet VA's commitment to deliver timely access to world-class health care and earned benefits to Veterans. The request fully funds over 9.1 million enrolled Veterans, including the continued operation of the largest integrated health care system in the United States and support for care delivered through community providers consistent with the MISSION Act. In 2025 it will also provide disability compensation benefits to nearly 6.9 million Veterans and their survivors and admin-

isters pension benefits for over 224,000 Veterans and their survivors. The 2026 Medical Care AA request includes a discretionary AA of $131.4 billion, plus a mandatory advance appropriation request of $22.8 billion for the TEF. The 2026 mandatory AA request is $222.2 billion for Veterans benefits programs (Compensation and Pensions, Readjustment Benefits, and Veterans Insurance, and Indemnities).

PACT Act

As of March 23, 2024, VA has received more than 1.3 million PACT Act-related claims and completed over 1,149,000 claims. Using the new PACT Act authorities, VA has granted service connection for over 10,000 terminally ill Veterans. VA will continue to award disability compensation to those Veterans who were subject to a presumption of service connection from the PACT Act. At the same time, in accordance with Title II of the PACT Act, VA is exercising the new presumptive decision process by studying acute and chronic leukemias and multiple myeloma as potential presumptions due to exposure to particulate matter in Southwest Asia. VA is also evaluating other conditions and exposures that may require formal reviews in the future.

In calendar year 2023, more than 361,000 Veterans were newly enrolled into VA health care, an increase of more than 73,000 from Fiscal Year 2022. Our 2023 health care enrollment efforts focused primarily on bringing in Post–9/11 combat Veterans during a 1-year special enrollment period created by Section 111 of the PACT Act. This targeted effort contributed to one of the largest health care enrollment growth periods in VA history. The special enrollment period for combat Veterans ended in September 2023 and, in that month alone, we enrolled 48,763 Veterans in VA health care. In comparison, the prior year's monthly enrollment total around that same time was about 26,000 Veterans.

VA expects our enrollment to continue to grow with the expedited implementation of Section 103 of the PACT Act. Originally planned to be phased in over several years, VA made this new health care eligibility effective in its entirety as of March 5, 2024. That means that toxic-exposed Veterans and those who supported certain overseas contingency operations will be eligible for care earlier than expected, affording our heroes with the world-class health care they have earned sooner.

Investing in Our People

Providing world-class service is only possible with employees who are the best and brightest in their respective fields. We are focusing on improving the employee experience so that they, in turn, deliver exceptional care and benefits to Veterans and their families, caregivers, and survivors. We are increasing the use of incentives for recruitment and retention, maximizing the use of existing pay and scheduling authorities as well as the new authorities recently enacted by Congress in the PACT Act, expanding scholarship opportunities, and providing more education loan repayment awards than ever before. From October 1, 2021 through March 23, 2024, we have hired 14,447 new VBA claims processors – growing our claims processing workforce by approximately 58 percent – and increased the total size of VBA to more than 33,900 employees, resulting in a record level of claims processing. As a result, VBA has completed 1,030,089 rating benefit claims in Fiscal Year 2024, as of March 5, 2024, 35 percent greater than this point in Fiscal Year 2023. Also, the disability compensation and pension claims backlog (comprised of claims pending for longer than 125 days) as a percentage of all claims received is at 38 percent as of March 5, 2024, compared to 70 percent in 2013, which is the last time the rating claims inventory was nearly this high. Forecast modeling continues to show VA remains on track to bringing the claims backlog to 100,000 claims or fewer by the end of 2025. Likewise, the Veterans Health Administration (VHA) hired nearly 62,000 new staff in Fiscal Year 2023 and, together with substantially improved retention rates, grew the health care workforce by 7 percent.

During 2023, VHA administered 4,845 scholarships for clinical education to employees and increased the number of new Education Debt Reduction Program (EDRP) awards to 3,398, which brought the total active EDRP participants to over 9,000. Additionally, the percentage of staff receiving recruitment, retention, and relocation incentives (3R) increased from 12 percent to 18 percent. At rural facilities, the use of 3Rs continued to climb in Fiscal Year 2023, increasing from 19 percent to 20 percent. In addition, for some critical shortage occupations, such as medical technicians (18 percent to 33 percent) and police (13 percent to 29 percent), the use of 3Rs increased even more dramatically. These incentives reduced losses for critical shortage occupations and helped VA successfully compete for health care and entry level staff. Additionally, VHA adjusted over 1,700 special salary rates, resulting in a 10 percent average increase in salaries impacting nearly 41,000 health care workers in support of PACT Act implementation. VHA also authorized critical skills in-

centives for over 28,000 employees in 37 different occupations as of the beginning of Fiscal Year 2024. The average critical skills incentive amount received by these employees was approximately $7,900.

Thanks to the robust hiring efforts in 2023, VBA and VHA are well-positioned to serve Veterans and need not continue the staff growth of 2022 and 2023 in 2024. Consistent with the 2025 budget, VA will strategically focus its hiring in key areas, to include mental health providers and front-line health care workers in regions with shortages.

Focusing on Wellbeing of Veterans

The Fiscal Year 2025 budget provides the resources that support Veterans' overall health and economic well-being. The Fiscal Year 2025 request includes $4 billion in discretionary funding for the VBA General Operating Expenses account, $136 million more than the 2024 President's Budget. This includes funds for increased overtime funding for the timely processing of claims and investments in artificial intelligence to improve key processes.

The President's Budget provides disability compensation and survivor benefits to over 7 million Veterans and their families, delivers education and job training benefits to1.1 million Veterans and qualified dependents, guarantees 433,000 home loans, and funds 5.6 million total lives insured for Veterans, Service members, and qualified dependents.

VA remains steadfast in our commitment to assist Veterans, active-duty Service members, and eligible surviving spouses in retaining their homes and avoiding foreclosure, having assisted over 145,000 borrowers to retain their homes in Fiscal Year 2023. VA has leveraged a suite of traditional and COVID–19 related loss mitigation options to aid borrowers who have trouble making mortgage payments. To address the needs of Veteran borrowers still experiencing the effects of the COVID–19 pandemic in a rising interest rate environment, or other economic shocks, VA plans to launch the Veterans Affairs Servicing Purchase program on May 31, 2024. This program will provide Veterans an affordable, scheduled monthly mortgage payment that reduces the debt owed over time at a rate much lower than the current market interest rate while eliminating the uncertainty resultant from balloon payments and payoffs.

Preventing Veteran Suicide

Suicide prevention requires a comprehensive public health approach. With a focus on evidence-based clinical interventions and community-based, evidence-informed prevention strategies, we aim to reach all Veterans—both those inside and outside of our system with life-saving interventions.

Suicide is a complex public health and national security issue. In addition to mental health risk factors for suicide, the evidence indicates that we assess a broader array of socio-economic and socio-cultural risk factors. With no single cause, there is no single solution, and we must be comprehensive in our approach as we know some Veterans may not receive any services from VA. To support this nationwide effort, the budget specifies $583 million for suicide prevention outreach programs, in addition to $2.7 billion in suicide prevention-specific treatment. Additionally, the budget plans to spend $17.1 billion in Fiscal Year 2025 for mental health care, a critical component of suicide prevention.

Our 10 year National Strategy on Preventing Veteran Suicide (2018) has been codified through VA's Suicide Prevention 2.0 Initiative, Suicide Prevention Now initiative, new laws including the 2020 Commander John Scott Hannon Veterans Mental Health Care Improvement Act, the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020, the National Suicide Hotline Designation Act of 2020, and emerging innovations like Mission Daybreak, combined with research and program evaluation. These efforts together help VA to reach all Veterans, not only those engaged in VA services. For example, in September 2023, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) awarded $53 million to 80 community-based organizations across 43 States, the District of Columbia, Guam, and American Samoa. These organizations provide or coordinate the provision of suicide prevention services for eligible individuals, including Veterans and their families. VA prioritized grants to rural communities, Tribal lands, Territories of the United States, areas with medically underserved groups, areas with a high number or percentage of minority Veterans or women Veterans, and areas with a high number or percentage of calls to the Veterans Crisis Line. Twenty-one grantees serve Tribal lands including the Navajo Nation, Cherokee Nation, Choctaw Nation, Alaskan Native Tribes, and others. VA published the Notice of Funding Opportunity for the SSG Fox SPGP on January 26, 2024, for a third year of services.

Increasing Access to Mental Health Care

Telehealth, especially video mental health care including substance use disorder treatment, has played a crucial role in improving access to mental health services. Video mental health care now constitutes 33 percent of total mental health care visits, showcasing the significant role of telehealth during and beyond the pandemic. In Fiscal Year 2023, over 1 million Veterans benefited from nearly 6 million video telemental health (TMH) care visits, marking a 5 percent increase in Veterans and a 1 percent increase in visits compared to Fiscal Year 2022; 96 percent of these TMH visits occurred in a Veteran's home or offsite location, emphasizing the convenience and accessibility of the service. Because most mental health visits can be conducted using TMH, it increases the available options for providing mental health care to all Veterans, no matter where they or their providers are in the U.S. This helps increase health care equity and access. Telehealth offers Veterans greater choice and removes their individual barriers to care—barriers such as stigma, transportation, distance to facility, childcare, financial constraints, logistical issues, and lack of access to in-person specialists who can deliver evidence-based interventions. Telehealth has become a primary consideration for Veterans seeking mental health care, with those in rural areas using video services at rates comparable to others. With plans to increase telehealth support staff and specialized providers, VA is to enhance its nationwide TMH network so even more Veterans can access mental health care virtually.

Among the risk factors for suicide, substance use disorder (SUD) is strongly implicated. In addition, drug overdose fatalities have escalated. The President's Budget includes $254 million to improve VA's opioid safety initiative and to continue our joint work with the Department of Defense (DoD) in the field of pain management, consistent with the requirements of the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114–198, Title IX, Subtitle A, §§ 911–912, the Jason Simcakoski Memorial and Promise Act). VA is also expanding evidence-based SUD treatment and harm reduction initiatives consistent with the Biden-Harris Administration's National Drug Control Strategy. The President's Budget includes $264 million to support VA initiatives that address Veteran specific needs, including employment, case management for Veterans experiencing housing instability, peer support, as well as in-patient, residential, and out-patient SUD care, delivered in-person and via telehealth, inside and outside specialty care settings.

Furthermore, VA's budget continues to support expansion of its Psychotropic Drug Safety Initiative to address the growing number of Veterans with stimulant use disorder and crisis of overdose fatalities associated with illicit stimulant use. This initiative increases Veterans' access to evidence-based treatments for stimulant use disorder and overdose prevention, while also ensuring the safe and appropriate prescribing of stimulant medications. Evidence-based treatments for stimulant use disorder include cognitive-behavioral therapy and contingency management, both of which are recommended by the 2021 VA-DoD Clinical Practice Guidelines (CPG) for the Management of SUDs.

Health Care Budget Request

Providing Veterans access to the soonest and best care is at the core of our mission. At a time when VA is expanding access to health care for millions of Veterans and delivering record numbers of appointments, VA is laser-focused on making sure that Veterans have access to world-class health care whenever and wherever they need it. In 2025, planned obligations for VA health care, including TEF, are projected to be $149.5 billion, an increase of 5.4 percent above the 2024 budget.

VA offers affordable, timely, and high-quality health care for the Nation's Veterans. In 2023, nearly 70 percent of VA hospitals receiving 4 or 5 stars in the annual Centers for Medicare & Medicaid Services Hospital ratings, compared to just 41 percent of non-VA hospitals. VA hospitals outperformed non-VA hospitals in all 10 core patient experience metrics in Medicare's latest survey of patients and, most importantly, more than 91 percent of the Veterans we serve trust VA with their care, a level unmatched anywhere in the private sector.

VA will ensure that every eligible Veteran has a chance to access VA care, including community care. We can now offer Veterans VA care at almost every turn, whether that is through an in-person appointment, telehealth appointment, placement in our community living centers, or another option. And that is exactly what we want to do.

Women Veterans' Health Care

In 2023, VA celebrated 100 years of providing health care to women Veterans. The budget requests $264 million for women's health and childcare programs. This

funding level supports $210 million for the Women's Health Innovation and Staffing Enhancement Initiative (WHISE). VA is strategically enhancing services and access for women Veterans by hiring women's health personnel nationally to fill any gaps in capacity across all Veterans Integrated Service Networks. Through WHISE, VA is funding over 1,000 women's health personnel including: primary care providers, gynecologists, mental health providers and women's health care coordinators, including maternity care coordinators. VA is also using WHISE funding to purchase needed clinical equipment such as new or replacement mammography equipment, exam tables designed for women with low mobility, and breastfeeding privacy pods.

Among eligible women Veterans receiving VHA care, more than half have at least one mental health condition and many struggle with multiple mental health concerns, medical comorbidities, and psychosocial challenges. These include gender-specific conditions, such as premenstrual dysphoric disorder, postpartum depression, and perimenopausal depression, all of which are associated with heightened suicide risk. VA has implemented numerous initiatives to ensure that women Veterans seen at any VA medical facility have access to mental health clinicians with the knowledge and skills to treat gender-specific mental health conditions, including reproductive mental health concerns. Examples include the National Reproductive Mental Health Consultation Program, comprehensive training in reproductive mental health across the lifespan, evidenced-based treatments tailored for women Veterans (as recommended by 2023 VA-DoD CPG for the Management of Pregnancy), and at least one designated Women's Mental Health Champion at each VA medical center (VAMC).

Women Veterans often feel a sense of connection and trust with peer specialists who can relate to their experiences in the military. Evidence shows that peer support is effective for alleviating some conditions unique to a woman's experience, such as postpartum depression. The President's Budget includes $2 million to support expanding peer support services for women Veterans. VHA is committed to honoring women Veterans' specific needs and treatment preferences by implementing national peer support training initiatives and disseminating novel, gender-tailored peer support interventions. These interventions are developed to be delivered both in person and via TMH to ensure greater access for women Veterans who often report barriers due to caregiving responsibilities.

Homelessness Programs

The 2025 budget provides $3.2 billion for Veterans' homelessness programs, with the goal of ensuring every Veteran has permanent, safe, sustainable housing with access to high-quality health care and other supportive services to end and prevent future Veteran homelessness. The budget includes funds to assist with designing and developing expanded services for aging and disabled Veterans, a growing need and area of focus for the Department of Housing and Urban Development (HUD) – VA Supportive Housing (VASH) program. In addition, funds will be used to provide a medical home model and population tailored approach to provide in-home primary care and wrap around services to Veterans actively enrolled in the HUD-VASH program, provide additional resources to increase outreach and community engagement efforts, as well as the expansion of Veteran justice services, such as treatment courts and Veteran-focused criminal justice initiatives. Funding will also support the VA Grant and Per Diem program to increase per diem rates to community partners actively supporting VA's effort to end Veteran homelessness.

On December 15, 2023, HUD, released the 2023 Point-in-Time Count, the annual effort to estimate the number of Americans, including Veterans, without permanent housing. Data show that on a single night in January 2023, 35,574 Veterans experienced homelessness in the U.S. Although this reflects a 7 percent increase in the number of Veterans experiencing homelessness from 2022, VA and our Federal partners have reduced Veteran homelessness by more than 52 percent since 2010. During calendar year 2023, VA permanently housed 46,552 homeless Veterans, surpassing the goal to house 38,000 Veterans by more than 22 percent.

Research

The 2025 budget requests a total of $927 million for research, which includes $59 in mandatory through the TEF funding. These resources will improve Veterans' health and well-being through basic, translational, clinical, health services, rehabilitative, genomic and data science research; apply scientific knowledge to develop effective individualized care solutions for Veterans; attract, train, and retain the highest-caliber investigators and nurture their development as leaders in their fields; and ensure a culture of professionalism, collaboration, accountability, and the highest regard for research volunteers' safety and privacy.

In 2025, the Office of Research and Development will coordinate with environmental exposure focused programs as part of the implementation of the PACT Act by building capacity (including the number of researchers funded to conduct military exposures research) and strengthening inter-governmental partnerships. This includes to implement an interagency workgroup on toxic exposure research, called for in section 501 of the PACT Act, to identify evidence gaps and craft a strategic plan to address gaps. The budget invests $59 million in 2025 for military environmental exposures research, an increase of $13 million from the current estimate for 2024.

Caregivers

The budget recognizes the important role of caregivers in supporting the health and wellness of Veterans and offers support and services through the Program of General Caregiver Support Services to family members and friends caring for a Veteran as well as through the Program of Comprehensive Assistance for Family Caregivers (PCAFC) to family caregivers caring for Veterans who meet specific eligibility requirements. The $2.9 billion included in the budget supports staffing, stipend payments, training, education, and other services to empower caregivers of Veterans. VA is currently undertaking a broad programmatic review of PCAFC to ensure it meets the needs of Veterans and their family caregivers. While this review is underway, VA has suspended annual reassessments for PCAFC participants. While the current eligibility criteria are examined, VA will not discharge or decrease stipends or support to PCAFC participants and their family caregivers, based on an annual reassessment. VA is also expanding services to family caregivers, to include specific suicide prevention training, mental health services, and respite services.

Connected Care

The 2025 budget includes $440 million for the Connected Care program and supports the ongoing expansion and enhancement of telehealth services directly to Veteran homes (e.g., video-to-home services); goals to standardize the availability of digital services for all Veterans; expansion of regional telehealth hubs, novel access and experience innovations; and the need to sustain previous expansion efforts funded with the support of the Coronavirus Aid, Relief, and Economic Security Act and the American Rescue Plan funding. VA delivered over 11.6 million telehealth episodes of care to Veterans in the last fiscal year. This includes over 9.4 million episodes of care to Veterans in their home or other locations and more than 2.9 million telehealth episodes of care to rural Veterans. Overall, VA provided telehealth services to over 2.4 million unique Veterans, representing about 40 percent of Veterans served in VA.

Aging Veterans

Because they make up a significant portion of the Veterans we serve, aging and older Veterans must be a significant priority now and in the future. Veterans over the age of 65 represent about 50 percent of all VHA enrollees. Currently, VA is expanding home-and community-based services. This expansion includes programs such as Veteran Directed Care, Medical Foster Home, and Home-Based Primary Care programs. All are aimed at enabling Veterans to age in place with the necessary support and services. VA is focused on implementing the VHA Institute for Healthcare Improvement's Age Friendly Health Systems initiative and VA's Geriatric Emergency Department Accreditation from the American College of Emergency Physicians initiative to prepare VA facilities and staff with the leading evidence-based care practices. VA is on a strong path to become the largest integrated age-friendly health system in the world. As of January 8, 2024, 132 VAMCs have earned formal Age-Friendly recognition in 305 care settings. The new 2024 VA Age-Friendly Health System initiative action community has projects registered for another 410 teams from 126 facilities. As of December 2023, 68 of the VA's 111 Emergency Departments earned Geriatric Emergency Room accreditation and others are actively in the process for 2024.

Infrastructure

The President's 2025 Budget includes $2.8 billion for construction requirements, including $2.5 billion in Major and Minor Construction appropriations and an estimated $307 million from the Recurring Expenses Transformational Fund (RETF) for VHA Minor Construction requirements. This request is $593 million greater than VA's discretionary 2024 request.

Funding for two major medical facility projects includes the West Los Angeles New Critical Care Center, Central Utility Plant, Demolition, and Renovations to Building 500 and Dallas Clinical Expansion for Mental Health, Expansion of Park-

ing Facilities, and Land Acquisition, together supporting over 400,000 Veteran enrollees. The 2025 budget also includes $45 million in Major Construction funds for a gravesite development project at Fort Logan National Cemetery in Denver, Colorado. The budget requests $687 million for Minor Construction, inclusive of RETF. This amount includes $174.1 million in Minor Construction funds to address gravesite expansion and columbaria requirements to keep existing national cemeteries open as well as address infrastructure deficiencies and other requirements necessary to support national cemetery operations. In addition, VHA's Medical Facilities account includes $2 billion for non-recuring maintenance.

Also included in the 2025 budget are nine major medical facility leases totaling over 1.9 million square feet of space supporting a workload of over 2.3 million outpatient visits and bed days of care per year. These leases are key to modernizing VA's clinical points of care and increasing access for the increasing number of Veterans anticipated to access VA care because of benefit expansion offered by the PACT Act.

Further, VA is aggressively working to pursue implementation of the goals of Executive Order 14057, which creates a broad set of challenging goals and requirements for Federal agencies to eliminate their carbon footprint and make their operations more sustainable and resilient. In support of this, VA's 2025 budget request includes Minor Construction funding totaling $7 million for the National Cemetery Administration (NCA) and VBA electric vehicle charging requirements.

Information Technology Serving Veterans

The 2025 budget provides $7.6 billion for VA IT systems and telecommunications support, including $6.2 billion in base discretionary funding and $1.4 billion in TEF, reflects the Office of Information and Technology's efforts to deliver modern, innovative, secure, and efficient solutions for the Nation's Veterans. To increase Veterans' access to VA information and services, strategic IT investments through the limited, controlled expansion of modernization, cybersecurity, and IT workforce, will allow VA to make key investments in Federal initiatives, including Zero Trust Architecture, Artificial Intelligence, and improved access for Veterans with certain disabilities through Section 508 Compliance.

To create a 21st Century VA focused on meeting the demands of Veterans in the digital age, IT modernization is critical in achieving digital transformation goals. The 2025 budget sustains the increased investments made in the 2024 budget and supports the continued operations and maintenance of VA's existing aging and legacy systems. VA continues to expand critical modernization initiatives bolstering the Department's ability to serve the Veteran including: the Infrastructure Readiness Program to reduce technical debt, Financial Management Business Transformation (FMBT) to enable compliance with financial management legislation and improve stewardship of resources, and Supply Chain Management to provide cost-effective logistics and ensure the delivery of world-class health care and benefits to Veterans.

When Veterans leverage technology to access VA services, they trust that the underlying digital ecosystem is safe, reliable, and secure. The 2025 budget invests $670 million in cybersecurity and VA's Zero Trust Architecture acceleration effort will deliver a robust and resilient security posture for the nine million Veterans that use VA for care and benefits and the hundreds of thousands of VA employees and contractors spanning over 600,000 connections to the network.

Investing in the IT workforce makes VA an attractive employer for top talent that can better deliver services to Veterans. The 2025 budget supports the Special Salary Rate authorized in 2023 for IT technical positions under PACT Act authorities. VA will maximize these incentives for targeted expansion of IT services – including Artificial Intelligence – to VA employees and Veterans during a period by record growth in health and benefits delivery. This investment is critical for VA to continue delivering world-class IT products and services to millions of Veterans, their families, and caregivers.

Electronic Health Record Modernization

As part of an Electronic Health Record Modernization Program Reset (Reset) announced in April 2023, VA deferred work on future deployments of the Federal electronic health record (EHR), the sole exception being the successful joint VA and DoD deployment at the Captain James A. Lovell Federal Health Care Center (North Chicago, Illinois) in March 2024, while the Department prioritizes improvements at the 6 sites and 22 clinics that currently use the Federal EHR. The purposes of the Reset are to: optimize the current state of the Federal EHR, closely examine and address the issues that clinicians and other end users are experiencing, and position VA for future deployment success. VA is seeing incremental, but accelerating progress as it addresses the issues that clinicians and other end users are experi-

encing and as it optimizes the current state of the EHR system to ensure the enterprise-wide foundation is in place for success when deployments resume. The Fiscal Year 2025 budget of $894 million supports the Reset and sustainment/maintenance of the six sites. VA acknowledges that an updated deployment schedule is critical to demonstrating commitment to providing the Federal EHR to end users across the enterprise and will provide that schedule to the Committee once it has been determined.

Financial Management Business Transformation (FMBT)

The 2025 budget includes $313 million for FMBT, a program that is improving VA's fiscal accountability and enhancing analytic and resource management capabilities for our employees who serve Veterans. Deployment of the Integrated Financial and Acquisition Management System (iFAMS) is taking place in phased implementations across VA Administrations and Staff Offices. Looking ahead, iFAMS will be implemented for VBA's Loan Guaranty Service, and the program recently initiated the first VHA implementation.

Honoring Veterans' Legacies

The President's 2025 Budget includes $495 million for NCA's operations and maintenance account, an increase of $15 million (3 percent) over the 2024 budget. These funds will ensure Veterans and their families have access to exceptional burial and memorial benefits including expansion of existing cemeteries as well as new and replacement cemeteries. With these funds, NCA will provide for an estimated 137,440 interments, the perpetual care of over 4 million gravesites, and the operations and maintenance of 158 national cemeteries and 35 other cemeterial installations in a manner befitting national shrines.

While every eligible Veteran may be interred at any one of VA's open national cemeteries and a significant majority of the 122 VA grant-funded Veterans cemeteries, VA realizes that proximity to a cemetery is an important consideration in whether Veterans and family members choose a VA-funded cemetery for their final resting place. For this reason, NCA is committed to providing 95 percent of the Veteran population with access to first interment burial options (for casketed or cremated remains, either in-ground or in columbaria) in a national or State Veterans cemetery within 75 miles of the Veteran's place of residence. VA has made continuous, significant progress toward meeting that target. In 2025, an estimated 94 percent of the Veteran population will be served with such access. The 2025 budget also includes $60 million for the Veterans Cemetery Grants Program to continue important partnerships with states and tribal organizations. The grants program plays a crucial role in NCA achieving its strategic target of providing 95 percent of Veterans with reasonable access to a burial option.

Additionally, the 2025 budget continues NCA's implementation of the Veterans Legacy Memorial (VLM), the Nation's first digital platform dedicated to the memory of nearly 10 million Veterans interred in VA's national cemeteries and VA grant-funded State, territorial, and tribal Veterans cemeteries. VLM allows family, friends, and others to preserve their Veteran's legacy by posting tributes. In November 2023, VLM 's website had its largest expansion yet with the creation of nearly 5 million pages for Veterans in private and other cemeteries who have received a headstone, marker, or medallion from NCA since 1996.

Conclusion

Chairman Bost, Ranking Member Takano, thank you for the opportunity to appear before you today to discuss our progress at the Department and how the President's Fiscal Year 2025 Budget and Fiscal Year 2026 Advance Appropriations Request will serve the Nation's Veterans.

Prepared Statement of Patrick Murray, Shane Liermann And Roscoe Butler

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

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

on
FY 2025 Budget for the Department of Veterans Affairs

House Committee on Veterans' Affairs
April 11, 2024

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

On behalf of The Independent Budget veterans service organizations (IBVSOs)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars (VFW)—thank you for the opportunity to present our recommendations to properly fund the Department of Veterans Affairs (VA) for fiscal year (FY) 2025 and FY 2026 advance appropriations, and to comment on VA's recent budget request for those years.

For more than 30 years, the IBVSOs have developed and presented recommendations to ensure that VA remains fully funded and capable of carrying out all aspects of its mission to serve our nations ill and injured veterans, their caregivers, surviving spouses and children—both now and in the future. Our detailed recommendations are contained in "The Independent Budget: Fiscal Years 2025 and 2026 for the Department of Veterans Affairs," which we submit for the record. Our testimony below contains an overview of the most significant funding recommendations and a comparison with VA's recent budget request.

At the outset, we note that VA's full-year appropriation for the current fiscal year (FY 2024) was not enacted for over five months after the start of the fiscal year due to continuing political disagreements that seem to grow worse every year. Although advance appropriations ensure VA can provide uninterrupted medical services and benefits in the event of a government shutdown, the threat of lapses in funding causes uncertainty and anxiety for veterans and complicates VA's ability to focus on its core mission. Further, the routine use of continuing resolutions that limit spending to prior year levels undercuts VA's advance appropriations for health care and prevents VA from expanding programs and services to more veterans. Congress must ensure that VA receives timely, adequate funding to meet the needs of veterans, their families, and survivors. Although conflicts and wars may draw to a close, the responsibility to these men and women is part of the cost of waging them and must remain a sacred national obligation.

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VETERANS HEALTH ADMINISTRATION

Veterans Medical Care

VA recently reported that more than 400,000 veterans had enrolled in the Veterans Health Administration (VHA) over the preceding 365 days, 30% more than the prior year. We project this trend will continue through next year as more veterans are enrolling and receiving higher priority eligibility as a result of the Honoring Our PACT Act. To meet this rising demand for care, adjust for inflation and a pay raise, and invest in critical health services, the IBVSOs recommend that VHA be provided a total of $152.8 billion for FY 2025, a 6.6% increase over FY 2024. Since VHA already received $21.5 billion in mandatory appropriations from the Toxic Exposure Fund (TEF) as provided in the Fiscal Responsibility Act (P.L. 118-5), we recommend a discretionary appropriation of $131.3 billion for VHA for FY 2025.

Long-Term Care

The fastest-growing segment of the veteran population are veterans over the age of 85, and the number of veterans eligible for nursing home care is projected to increase 535% over the next 20 years. To meet this coming silver tsunami, the IBVSOs recommend a $1 billion plus-up for the full spectrum of VA's long-term care programs, from skilled nursing care to home and community-based services.

Dental Care

It's long past time for VA to recognize that dental care is health care. Poor dental health has been linked with a number of serious medical conditions, including heart disease, diabetes, cancer, dementia, and Alzheimer's disease, and can have serious negative consequences for veterans' overall health outcomes. In order to begin expanding dental care eligibility to all enrolled veterans, the IBVSOs recommend a plus-up of $590 million in FY 2025 to grow VA's in-house capacity, as well as additional resources for community care coverage.

Mental Health and Suicide

Over recent years, we have supported a number of landmark laws passed by Congress to address suicide, yet VA's most recent 2023 National Veterans Suicide Prevention Report noted veteran suicide is not decreasing. To strengthen VA's efforts to address the crisis of veteran suicide, the IBVSOs recommend a plus-up of $150 million for FY 2025 to add 1,000 additional mental health personnel. The funding will also help VA to continue recruiting and retaining mental health providers, care coordinators, and administrative support staff.

Women Veterans

With more than 650,000 women veterans now enrolled in VA health care, there have been significant improvements in gender-specific care over the past decade. To continue this progress, and address gaps that still exist, the IBVSOs recommend a plus-up of $160 million for VA to recruit and train more providers in gender-specific care for women veterans; increase the number and quality of peer support specialists; expand maternity care coordinators; and strengthen the Office of Women's Health and the Center for Women Veterans.

Medical Research

VA's Medical and Prosthetic Research program generates discoveries that measurably contribute to improving the health of veterans and all Americans. The research program also supports VA's recruitment and retention of healthcare professionals and clinician scientists. For FY 2025, the IBVSOs recommend a total of $1.05 billion for VA research. With $59 million in mandatory TEF funding already approved, we recommend $946 million in new discretionary appropriations.

Health Care Infrastructure

There are over $130 billion in backlogged infrastructure projects, and the backlog is growing every day. Yet, appropriations for construction and maintenance of health care facilities in recent years has been woefully inadequate. Unless VA and Congress begin making serious investments in health care infrastructure, the VHA system will increasingly struggle to maintain high-quality, accessible care that our veterans have earned.

For FY 2025, the IBVSOs recommend $5.2 billion for VA Major Construction, more than four times the current year's funding level. For Minor Construction, the IBVSOs recommend $910 million, a 30% increase over FY 2024. We also call for a plus-up of $900 million to address the serious backlog of nonrecurring maintenance projects throughout VA's medical facilities. In addition, the IBVSOs recommend an increase of 350 full-time employees (FTE) so that each of VA's major medical centers or other appropriate regional locations have personnel to plan and oversee construction projects.

VETERANS BENEFITS ADMINISTRATION

Due in large part to the passage of the PACT Act, veterans submitted over 2.4 million claims in FY 2023 for benefits, primarily disability compensation, which is 39% higher than the prior year. The Veterans Benefits Administration (VBA) processed 1.9 million benefits claims in FY 2023, surpassing the previous all-time record by 16%. To address the rising workload that is expected to continue through next year, the IBVSOs recommend a total of $6.2 billion for VBA in FY 2025, a 9.1% increase. This total includes plus-ups of $130 million for additional overtime to process claims and $75 million to improve VA's mail processing with new technologies. Since $1.4 billion in mandatory TEF funding is already approved, Congress would need to provide $4.8 billion in new discretionary appropriations for FY 2025.

BOARD OF VETERANS' APPEALS

The Board of Veterans' Appeals (BVA) continues to resolve more appeals in recent years, yet at the start of FY 2024, there were still over 200,000 appeals pending; 72,000 of those were awaiting hearings. For FY 2025, the IBVSOs recommend $333 million for BVA, a 14% increase over the FY 2024 appropriation from all sources. With $62 million in mandatory TEF funding already approved, the IB recommends $271 million in new discretionary appropriations, which includes a plus-up of 220 new FTE to address rising workload.

NATIONAL CEMETERY ADMINISTRATION

With the demand for burial space increasing as the nation's veteran population is aging, the IBVSOs recommend $626 million for the National Cemetery Administration (NCA) in FY 2025, a 30% increase over the FY 2024 level. This funding includes plus-ups of $60 million for accelerated expansion and maintenance of national cemeteries; $50 million for the National Shrine and Legacy Memorial programs; $10 million to expand outreach for awareness and utilization; and $5 million for an innovative pilot program to train and employ homeless veterans. Although NCA does not get the same level of attention as VHA and VBA, it provides a final benefit and tribute to the men and women who served and should receive the appropriate level of resources to match its commitment.

ANALYSIS OF VA'S FY 2025 BUDGET REQUEST

Overall, the Administration's FY 2025 VA budget request takes another positive step forward to help fulfill our nation's obligations to America's veterans. Compared to the IBVSOs' recommendations, the VA request meets or comes close to meeting our recommendations for a number of VA programs. However, the level of funding requested for infrastructure continues to be a major concern for the future of VA health care. There are also some trends that raise concerns, particularly VA's use of alternate means of funding, the reduction of health care personnel, and the continued over-reliance on community care rather than investing in VA's internal capacity.

Alternate Sources of Funding Health Care

The Independent Budget is developed based on projecting the total need for resources to be provided through the annual appropriations process. The IB did not take a position on the creation of the TEF and its mandatory funding mechanism, but those resources are taken into consideration in our budget recommendations. However, we do have significant concerns with VA's increasing reliance on alternate streams of funding in lieu of new discretionary appropriations. In addition to the mandatory TEF funding ($24.4 billion) in VA's budget submission, there is the Medical Care Collections Fund (MCCF) ($4.4 billion) and a planned carryover of $12.7 billion that would come from unspent FY 2024 appropriations.

In the past, VA has often over-estimated the impact of alternate streams of funding, such as the MCCF, which can result in a shortfall of funding, usually manifesting late in a fiscal year. Unless the VA requests, and Congress approves, a supplemental appropriation, the gap in funding will have to be made up by cutting back on VA programs and services for veterans.

In its current budget submission, VA has proposed to carryover virtually the entire unobligated balance projected to be available at the end of FY 2024 in lieu of seeking new FY 2025 discretionary appropriations. This appears to be part of an effort to keep the Administration's overall discretionary appropriations request under the negotiated caps imposed by the Fiscal Responsibility Act. We are concerned about whether this could result in VA constraining its spending this year to meet that target, irrespective of veterans' actual need for medical care and other services. If the substitution of $12.7 billion in carryover funding for new appropriations is approved by Congress, but the available unobligated balance ends up being less, we are concerned that in the current political fiscal and political environment, it will be difficult to enact a supplemental appropriation to fill that funding gap.

VA-Provided Care vs. Community Care

Over the past decade, VA's reliance on and spending for purchased medical care services from community providers has risen dramatically. While the IBVSOs agree that veterans must have options whenever and wherever VA is unable to provide timely, accessible, and high-quality care, research continues to show that the quality of care provided by VA is better than the private sector on average. There is also abundant evidence that the majority of veterans who enroll in the VA health care system prefer to be treated by VA, not the private sector. The best way to ensure optimum health care outcomes for veterans is to maintain VA as the primary provider and coordinator of veterans' health care, a position supported by current and past VA Secretaries and Under Secretaries of Health serving in administrations of both political parties.

While the FY 2025 VA budget submission does request an overall 6.6% increase in medical care resources, it does not allocate that funding to expand VA's capacity to provide care, and thus, reduce its reliance on community care providers. Instead, VA's budget submission would grow annual spending for community care at a faster rate than VA-provided care through at least FY 2026. Specifically, according to VA's budget submission, obligations for Medical Community Care would rise 12.9% this year, 10.7% in FY 2025, and 10.7% in FY 2026, compared to VA care increases of 8.4%, 5.1%, and 4.0%, respectively. This trend must be stopped and reversed.

Investing in Personnel and Infrastructure to Build VA Capacity

In order to expand VA's health care capacity in the future, the IBVSOs' recommendations include a $2.8 billion Medical Care plus-up to fill approximately 25% of VA's health care vacancies. By contrast, VA's FY 2025 request would result in a reduction of 10,000 health care FTE. Among the positions eliminated would be about 600 physicians, 2,400 nurses, 500 non-physician providers, and over 2,000 health care technicians. According to VA's most recent Section 505 Vacancies Report for the first quarter of FY 2024, there are a total of 66,000 vacancies in VHA, which include 3,200 physicians and 16,000 nurses, practical nurses, and nursing assistants.

The IBVSOs are also concerned about growing anecdotal evidence that many VA facilities have stopped hiring and are removing vacancy announcements due to a shortage of funding to fill those positions. Although VA has significantly increased its staffing in recent years, the number of veterans who enroll, use, and rely on VA for their medical care continues to grow thanks to important new legislation like the PACT Act. Congress must provide sufficient resources to fully fund VA's staffing needs, without offsetting those increases by cutting other veterans programs, services, or benefits.

The IBVSOs' recommendations also include a $4.4 billion (266%) increase in Major and Minor Construction to repair, modernize, and replace VA health care facilities. Regrettably, VA has requested a total of only $2.8 billion for Major and Minor Construction, even though VA's own Strategic Capital Investment Plan indicates there needs to be an average of $8.5 billion invested for each of the next 10 years to maintain VA's health care infrastructure. In fact, VA's FY 2025 request for Major and Minor Construction from all sources (including TEF and the Transformation Fund) is actually 33% lower than what VA requested last year.

We also note that VA's request for the State Home Construction Grant Program is just $141 million, $30 million less than VA received this year, despite a backlog of approved projects that have a federal matching share of approximately $1.3 billion. The IBVSO recommendation for FY 2025 is $600

million, which would fund about half of these already-approved Priority 1 construction projects. Since State Veterans Homes provide more than half of all VA-supported nursing home beds for aging and disabled veterans, there would be fewer options in the future if Congress does not adequately support this important program.

Budget Caps and PAYGO

Finally, given the fiscal and political challenges that seem to be increasing, the IBVSOs believe it is time for Congress to make additional reforms to the budget and appropriations process for veterans programs, benefits, and health care. Although VA funding has fared well in recent years, the long-term impact of budget caps on discretionary spending levels has increasingly put pressure on VA and Congress to limit funding for veterans programs. While one of the reasons asserted for creating the mandatory Toxic Exposure Fund was to relieve pressure on VA's discretionary appropriations, the budget caps enacted by the Fiscal Responsibility Act last year have clearly constrained VA's most recent budget submission, which underfunds some critical priorities, including infrastructure, medical research, VA health care, and VBA claims processing.

In addition, Congressional PAYGO ("pay-as-you-go") budget rules continue to limit expansion and improvement of many critical VA benefits and services for veterans, particularly disabled veterans. Most recently, the Congressional Budget Office has determined that PAYGO offsets will be increased for any programs that are in part funded by the TEF, creating even more fiscal obstacles that must be overcome to provide veterans the care they deserve.

The IBVSOs call on Congress to exempt veterans programs, services, and benefits from congressional PAYGO (and "Cut-Go") rules, as well as from sequestration, rescissions, and budget cap deals. Keeping our promises to the men and women who served is a sacred obligation that should never be leveraged against other veterans or other national responsibilities. America's veterans have already "paid" enough through their service and sacrifice to the nation; which includes the service and sacrifice of their families, caregivers, and survivors.

Mr. Chairman, that concludes our testimony, but the complete details of the IB Budget Recommendations for FY 2025 and FY 2026 can be found at www.IndependentBudget.org. We would be pleased to answer any questions that you or members of the Committee may have about VA's budget for FY 2025.

STATEMENTS FOR THE RECORD

Questions for the Record Submitted by Juan Ciscomani, Jennifer Kiggans and Morgan McGarvey

House Committee on Veterans' Affairs
"U.S. Department of Veterans Affairs Budget Request for Fiscal Years 2025 and 2026"
April 11, 2024

Questions for the Record

Rep. Ciscomani

1. I recently introduced legislation to expand skilled trade programs available under the GI Bill, H.R. 7896, the VETS Opportunity Act. The budget request would reduce the number of Veteran Readiness and Employment counselors. How will VA ensure there are enough counselors available to connect veterans with these in-demand careers?

2. The budget request includes a goal of hiring 1,000 women's health specialists in the Women's Health Innovation and Staffing Enhancement Initiative. This is important because there is a national shortage of women's health providers that is expected to continue to grow. How did VA come up with this number and how will the VA accomplish this hiring goal when confronted with these barriers? What accountability will there be if this goal is not met?

3. The budget request would reduce funding for the Board of Veterans' Appeals. Given this, how does VA plan to address the Board's workforce challenges and the backlog of claims?

4. What is VA's plan to address the high number of remanded appeals?

5. Local veteran service organizations have reported that some Veterans Health Administration executives and medical center directors do not feel that homeless coordinators are a hospital function, and they would like those positions to be cut. What is VA's official position on whether homeless coordinators should remain a hospital function? Will the homeless coordinator roles remain in place?

Rep. Kiggans

1. The budget request drastically reduces community care funding by more than 30% in fiscal year 2025 compared to fiscal year 2024. What is the rationale for this?

2. What is VA doing to ensure that community care providers have the resources they need to reduce appointment times and increase care capacity?

3. Suicide prevention is mentioned as "VA's top clinical priority" in the budget request. I am glad to see that the budget for prevention outreach is being increased, but I am concerned that progress in the fight against veteran suicide is stalling. How is VA using lessons learned to improve funding for existing programs?

4. The fiscal year 2025 VA budget request is the largest in history at $369.3 billion ($32.9 billion or 9.8% above fiscal year 2024). This is following historic fiscal year 2024 funding levels passed

through Congress, that I voted for earlier this year. What are VA's top priorities with the additional funding requested?

5. Whistleblowers at the Hampton, Virginia VA medical center, the VA facility most used by my constituents, have brought forward disturbing allegations of misconduct by staff and leadership, which the Subcommittee on Oversight and Investigations is investigating to the full extent of its jurisdiction. Does VA commit to responding expeditiously to the information requests that Chairman Bost and I have sent regarding this investigation?

6. Does VA believe adequate resources are devoted to oversight of the medical centers, in the Office of Inspector General account and other accounts?

Rep. McGarvey

1. With the population of women veterans growing by more than 30% over the past five years, VA's fiscal year 2025 budget request includes only a 3% increase in funding over fiscal year 2024 ($264 million for women's health and childcare programs, an increase of $6.7 million or 3%). A major part of improving health services for aging women veterans will be clinical research, but allocation for research into women's health is not listed in the budget. In fact, there are cuts to Office of Research and Development funding across the board. How does VA plan to invest in research on aging women veterans' issues, specifically menopause and mental health?

2. The budget request includes $18 million to deliver on the *Deborah Sampson Act* provision to offer childcare support for some veterans during medical appointments. Updates from VA indicate that early attempts to pilot a drop-off program with local day care facilities have not gone well because the market has not been responsive to requests for information in most of these areas. With VA exploring other avenues of providing support, like a stipend program similar to beneficiary travel, what is the plan to allocate the $18 million? How will the funding be used to design, test, and scale a model(s) of childcare support that works for veterans and their families?

3. Mounting evidence indicates that social drivers such as housing, transportation, food, education, employment, access to broadband, and even social connection all have major impacts on an individual's health. VA offers many great programs to address these needs, but what is being done specifically in the area of loneliness and social isolation?

4. According to the 2023 Surgeon General's Advisory on Loneliness and Isolation, loneliness is more than just a bad feeling; it is associated with a greater risk of cardiovascular disease, dementia, stroke, depression, anxiety, and has the same mortality impact of smoking 15 cigarettes per day. The full report outlines recommendations on what can be done by federal agencies like VA to address this issue. What has VA done, and what does VA plan to do, in response to the following recommendations:

- Establish a dedicated leadership position to work across departments, convene stakeholders, and advance pro-connection policies.
- Create a standardized national measure for social connection and standardized definitions for relevant terms.

- Prioritize research and innovation funding to evaluate programs aimed at improving social connection.
- Deploy public education and awareness efforts, including the development of national guidelines for social connection.

U.S. Department of Veterans Affairs Response to Questions for the Record Submitted by Mike Levin and Julia Brownley

118th Congress, 2nd Session
Department of Veterans Affairs
Requestor: Representative Levin (D-CA-49)
Request for Information
HVAC Hearing: VA FY25 and FY26 Budget Request
11 April 2024

Question:
When will the Veteran and Spouse Transitional Assistance Grant Program, under the Outreach, Transition and Economic Development (OTED) Service, open its application on grants.gov?

VA Response:
The Department of Veterans Affairs (VA) is diligently working to implement the Veteran and Spouse Transitional Assistance Grant Program (VSTAGP). On May 13, 2024, VA published the final regulation in the Federal Register, which will be effective June 12, 2024. VA will post the Notice of Funding Opportunity on www.grants.gov in June 2024 and will remain open for a minimum of 30 days for application submission.

118th Congress, 2nd Session
Department of Veterans Affairs
Requestor: Representative Brownley (D-CA-26)
Request for Information
HVAC Hearing: VA FY25 and FY26 Budget Request
11 April 2024

Question:
It is difficult to determine whether the budget allocated for gender specific care is proportional to the growing rates of utilization of women and other gender specific care, so do you have data to compare metrics over five or ten year period?

VA Response:
See attached chart illustrating obligations and patient metrics within gender-specific care.

118th Congress, 2nd Session
Department of Veterans Affairs
Requestor: Representative Brownley (D-CA-26)
Request for Information
HVAC Hearing: VA FY25 and FY26 Budget Request
11 April 2024

VA Medical Care, Gender Specific Care

Table 1. Gender Specific Care

FY	2019	2020	2021	2022	2023
Obligations ($ in thousands)	$ 532,565	$ 564,800	$ 628,800	$ 739,273	$ 851,443
Year-over-year change (%)		*6%*	*11%*	*18%*	*15%*
Cumulative change, FY 2019-2023					*60%*
Unique Patients	316,227	300,172	332,377	355,877	385,897
Year-over-year change (%)		-5%	11%	7%	8%
Cumulative change, FY 2019-2023					*22%*
Outpatient Encounters	1,360,341	1,253,136	1,474,778	1,631,714	1,712,667
Year-over-year change (%)		-8%	18%	11%	5%
Cumulative change, FY 2019-2023					*26%*
Inpatient Bed Days	21,762	25,518	22,284	23,047	21,908
Year-over-year change (%)		17%	-13%	3%	-5%
Cumulative change, FY 2019-2023					*1%*

Source:

Obligations	VA Congressional Justification
2019	FY 2021, Vol. II, pg. VHA-178
2020	FY 2022, Vol. II, pg. VHA-282
2021	FY 2023, Vol. II, pg. VHA-310
2022	FY 2024, Vol. II, pg. VHA-316
2023	FY 2025, Vol. II, pg. VHA-346

Unique Patients	VA Congressional Justification
2019	FY 2021, Vol. II, pg. VHA-189
2020	FY 2022, Vol. II, pg. VHA-289
2021	FY 2023, Vol. II, pg. VHA-316
2022	FY 2024, Vol. II, pg. VHA-320
2023	FY 2025, Vol. II, pg. VHA-349

Utilization Data

Based on the encounters with women's health specific diagnosis codes, women's health DRGs and Women's clinics.