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IDA Health Watch

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Senior Leader Interview

DR. TERRY ADIRIM, ACTING ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Terry Adirim, M.D., M.P.H., M.B.A., was appointed Principal Deputy Assistant Secretary of Defense and is currently serving as the Acting Assistant Secretary of Defense (ASD) for Health Affairs. As the Acting ASD, Dr. Adirim is the principal advisor to the Secretary of Defense and the Under Secretary of Defense for Personnel and Readiness for all Department of Defense (DoD) health and force health protection policies, programs, and activities.

Previously, Dr. Adirim was Senior Associate Dean for Clinical Affairs, Professor of Pediatrics, and Chair of the Department of Integrated Medical Sciences at the Schmidt College of Medicine at Florida Atlantic University (FAU) in Boca Raton, Florida. Prior to her position at FAU, Dr. Adirim served as the Acting Principal Deputy Assistant Secretary of Defense for Health Affairs and Deputy Assistant Secretary of Defense for Health Services Policy and Oversight. Previously, she held senior leader policy positions in the U.S. Department of Homeland Security, the U.S. Department of Health and Human Services, and academic medicine. She practiced pediatric emergency medicine for over 25 years.

You returned to Washington in the midst of the COVID pandemic. What do you think are the enduring lessons learned from the response to date? What have been the most significant management challenges?

I left the DoD in February of 2020, right before the pandemic really started in the United States, and returned in January of 2021. So, I base my comments on what I have observed over the last 4 months and my understanding of what transpired. DoD had some bumps in the response early on, but this is to be expected when a disaster of this scale takes place. DoD ultimately rose to the challenge and really was able to do what needed to be done at the time. From my perspective, there were four lessons that emerged from the pandemic.

First, I was impressed with the Force Health Protection guidance that was well thought out and quickly disseminated. The department created a process of synthesizing what is known about COVID-19 into actionable guidance to protect the force. Second, we do not allocate resources to long-term threats. It is a real challenge to plan for a pandemic of this magnitude as a whole government. Resourcing to meet these long-term threats is a big lesson we will need to consider in the future. The response required a lot of resources in a very short period of time. A good example of this was the COVID testing program. We invested a lot of funding into testing and developing a testing strategy—when testing was not widely available. Another example was the widespread shift to working remotely. I don't think the department was prepared for a large part of the workforce suddenly working from home. In rapid time, they had to purchase additional computers and technologic capability in order to ensure the safety of the workforce while maintaining continuity of operations. Third, the MHS [Military Health System] was in the middle of a transformation and transferring management of MTFs [Military Treatment Facilities] to the DHA [Defense Health Agency]. Previously, each of the military departments was managing their MTFs, so we had four distinct entities responding without the centralized coordinating mechanism to get everyone on the same page. Moving forward, the DHA will be managing things. I think this experience speaks to the need to have DHA support. For instance, DHA has been coordinating COVID vaccination across the DoD. I think they have demonstrated they were able to do that extremely effectively through centralized management and coordination within a single agency. This

kind of centralization and standardization was missing from the initial response to the pandemic. Lastly, I think you can never communicate enough, particularly during a disaster scenario. Communication could have been augmented during the early months of the pandemic.

Has the pandemic challenged the assumptions of previous reform efforts (e.g., reductions to the medical force, downsizing of select MTFs, consolidation of MTF management under DHA)?

I think the pandemic has forced a relook of how we are reshaping the health system particularly with respect to how much we rely on the civilian health sector and what the MTFs should look like in the future. We are still proceeding with Section 702 implementation—the transfer of management of MTFs to the DHA. We are still proceeding with Section 703 and right-sizing the MTFs, but because of the pandemic there was a pause in the implementation of these efforts. In November of 2020, the reform efforts resumed, and we decided to take another look at the 703 reforms to determine whether the pandemic has impacted the health systems around MTFs selected for downsizing. We are currently revalidating the analysis and developing implementation plans to [ensure] that the way forward does not impact quality or access for beneficiaries. With respect to manpower reforms, and I can't speak for the [military departments], but I think one or more of them will take a closer look to determine if the pandemic changes the approach to meeting any reductions in the medical force. I don't know if the pandemic has changed their thinking, but going forward the priority is going to be on shaping the system to meet medical readiness requirements.

As we consider a return to a new normal, what priorities do you have for the MHS? Where will leadership focus in the coming years?

I think there are really two key priorities. The first is to complete the congressionally directed reform efforts. I think we need to not just complete the transfer of MTFs to DHA, but to ensure the success of the Defense Health Agency to administer and manage MTFs so that they continue to advance the delivery of high-quality care for all beneficiaries. All the other reform efforts sort of fall under that. The second priority is that the MHS is really ready to respond to future threats and that we really underscore our value to the military departments. We need to shore up our ability to save lives on the battlefield, maintain skills of our uniformed medical providers, and ensure that we are resourced to respond to those future threats. This also includes ensuring that our research and development is forward leaning.

What about expanding military-civilian partnerships to address medical readiness?

I think these types of partnerships should be used to fill in where there may be gaps in our system. The MTFs should be filling the readiness needs of the military departments. What I mean by this is that the MTFs should be the first-choice readiness platform to not only ensure that our troops are ready, but that the medical providers can maintain their clinical skills. The military-civilian partnerships should be used to fill in any areas where there may be gaps.

What about the new TRICARE contracts? How will the new T-5 contracts support readiness?

TRICARE is a very important piece of the MHS. The T-5 contract will facilitate our ability to implement pilots and demonstrations on innovative approaches that we cannot do currently. First, I think this is going to be an opportunity to look at new ways that we can provide care to service members and beneficiaries. Second, I think it is an opportunity to rebalance risk within the contracts. Under the current plans, we have a fee-for-service model, but under T-5 we will be able to move towards value-based models and share risk with the contractors. We see T-5 as a bridge to contracts that can really help us emphasize readiness. The contracts will have strong incentives or features to ensure that the readiness case mix is staying in the direct care system to maintain the readiness of uniformed providers. We will also require quality measures that align to MTF quality measures. This means that TRICARE and MTFs will be measured in the same way.

The pandemic catalyzed many changes already underway in health care (e.g., telehealth, digital transformation, data availability and analytics, and distance learning). How do you build upon this momentum to improve care in the MHS? Where do you think are the high-yield areas for improvement?

I think the biggest change has been in virtual health, which I am glad to see. The civilian sector has found the expansion of virtual health to be really valuable—like expanding access to behavioral health. We are also looking at other strategies to leverage virtual health to be more efficient and expand access to care. These strategies can be provider to provider, but also provider to patient. The data and digital transformation were both well underway before the pandemic, but I will say that the pandemic really underscored the need to be able to forecast and predict. I think this is something we have historically done a pretty good job with. The new EHR [Electronic Health Record], however, expands our capability in data collection and analytics. MHS Genesis generates a lot of data and will be critical to our ability to forecast and conduct analysis, particularly as the VA [Department of Veterans Affairs] implements its own version of the same platform at more of its facilities. We will have a great deal of data from which to gain insights into the health and health care of our service members and veterans.

How have providers in the MHS responded to MHS Genesis?

I think there is a lot of good news here. We learned a lot from the rocky start and have been able to learn from our initial implementation. I think the program addressed its issues early and developed a standardized methodology for implementation that accounts for all the complexity—like managing all the devices that connect or interface with the EHR, getting the MTFs on the [Medical Community of Interest] early, doing the training in advance, and having super users who can pay it forward. All of these things have made implementation increasingly routine. We just had one of the biggest waves deploy out west and it really has been one of the smoothest. All the upfront work is paying off now in the later waves, helping us deploy even faster.

Policy Watch

TRICARE BENEFITS FOR RESERVISTS

Sarah K. John

During the last several months, the National Guard Bureau has increased calls for expanding TRICARE benefits for troops in the National Guard. In May, General Daniel Hokanson, Chief of the National Guard Bureau, told Congress that premium-free health care for all National Guard members was his "Number 1 legislative priority."[1]

In May, a bill that would make no-fee health care available to the over 800,000 Reserve Corps Service Members (RCSMs); including Reserve and National Guard members was introduced in the House of Representatives. The "Healthcare for Our Troops Act" is co-sponsored by the co-chairs of the National Guard and Reserve Caucus, Reps. Tim Ryan and Steven Palazzo.

How Does Health Care for Reservists Currently Work?

The Department of Defense (DoD) provides a health benefit known as TRICARE to service members on active duty. According to TRICARE eligibility rules, when RCSMs are in an inactive status (i.e., working in their civilian occupation), they do not qualify for the primary TRICARE benefit. When they are activated on orders of 30 days or more, they become eligible.[2] The result is that most RCSMs repeatedly transition between civilian-provided insurance coverage and the TRICARE program. Some also go uninsured.

Although inactive RCSMs are not eligible for the active duty TRICARE benefit, they are eligible to purchase the premium-based TRICARE Reserve Select (TRS) benefit. The TRS benefit is an affordable health benefit compared to other civilian options. Table 1 shows the TRS annual premiums (for self and family plans) alongside the national average for premiums paid by those enrolled in employer-sponsored health care plans and several popular Federal Employee Health Benefit (FEHB) plans, which are available to government civilian employees.[3] On average, employees contributing to their employer's sponsored plan pay twice as much as the TRS premium.

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[1] Steve Beynon, "Free Health Care for All Troops Is Key Priority, National Guard General Tells Congress," Military.com, 2021, https://www.military.com/daily-news/2021/05/18/free-health-care-all-troops-key-priority-national-guard-general-tells-congress.html.

[2] Several transitory benefits, including Early Alert (up to 180 days before orders) and the Transitional Assistance Management Program (up to 180 days after orders end), provide premium-free coverage for those that qualify. A premium-based program called the Continued Health Care Benefit Program (CHCBP) is also available for 18 to 36 months.

[3] Data on the National Average Employee Premiums come from the 2020 Employer Health Benefit Survey available at https://www.kff.org/report-section/ehbs-2020-section-1-cost-of-health-insurance/. Data on FEHB premiums is from the Office of Personnel Management at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/premiums/#url=premium2020.

Table 1. Annual Employee Premium Contributions (2020)

Plan	Member Only	Family	Civilian Plan Cost to TRS Cost
TRS	$530	$2,739	—
National Average	$1,243	$5,588	2.0
Select FEHB Plans:			
BCBS Standard (high-tier)	$2,829	$6,558	2.4
BCBS Basic (mid-tier)	$1,975	$4,972	1.8
GEHA (low-tier)	$1,574	$4,044	1.5

RCSMs who opt to enroll in the TRS benefit also face a deductible ($156 individual/$313 family) and out-of-pocket (OOP) costs (co-pays and/or coinsurance rates). The catastrophic cap, the most a family will need to pay out of pocket, is $1,058 per year. Although TRS premium and OOP costs are relatively low compared to civilian benefit plans, they are higher than the active duty benefit (often zero OOP costs).

What Does the National Guard Want?

The National Guard seeks to provide its members with a "premium-free" health care benefit. Although the proposed premium-free benefit design is undefined, it could take the form of the current TRS benefit (but with the premium reduced to zero) or the TRICARE Prime benefit currently available only to activated RCSMs.

Proponents of expanding TRICARE benefits for RCSMs argue it would provide human resource benefits such as improved recruitment and retention. Given that a health benefit is a form of compensation, this is likely true; however, the magnitude of the impact is unknown. It is also possible that lower cost options (such as cash payments) would be more effective at achieving these objectives. Improving RCSM medical readiness, reducing challenges associated with transitioning between civilian and DoD coverage, providing care to the uninsured, and providing access to mental health services have also been cited as potential benefits of expanding RCSM TRICARE benefits. Further research is needed to determine whether these benefits outweigh their significant costs. In addition, careful analysis will be needed to determine whether the current TRICARE provider network could absorb such a large increase in beneficiaries without impacting access standards.

As policymakers weigh the potential benefits and costs of expanding TRICARE benefits for RCSMs, they should consider factors such as how much substitution will occur (RCSMs switching from civilian insurance to TRICARE) and how different plan designs could affect utilization (e.g., waiving premiums only versus waiving premiums and OOP costs). Lower cost options—such as waiving premiums for junior-enlisted only, providing subsidies to use an employer's insurance plan, or expanding pre- and post-activation benefits—could also be explored.

Research Spotlight

COVID-19 AND HEALTH EQUITY

W. Patrick Luan

The COVID-19 pandemic stressed the American health system across the nation. However, the challenges and stressors differed according to myriad factors and causes. In densely populated urban centers like New York and Los Angeles, hospitals quickly reached capacity, and ensuring adequate staffing was a challenge. In rural communities, providers needed to communicate effectively to adapt to the rapid implementation of virtual care. As these forces played out, they exposed the magnitude and ubiquity of inequities—defined here as "avoidable, unfair, or remediable differences in health." In this Research Spotlight, we highlight research documenting some of these inequities.

- Polyakova et al. used the Social Security Administration's Numerical Identification (Numident) database to document racial disparities in mortality during the early stages of the pandemic. The authors found that excess all-cause mortality differed substantially across racial and ethnic groups after adjusting for age, sex, and state of residence. White and Asian people had the lowest excess mortality (at 1.5 and 2.7 excess deaths per 10,000, respectively) whereas Hispanic and Black people had 4.3 and 6.8 excess deaths per 10,000 over the same period. Interestingly, racial disparities exhibited heterogeneous effects across states. States most affected during the early stages of the pandemic, such as New York and New Jersey, exhibited excess mortality for Hispanic and Black populations two to three times the levels seen for the White population. Some states with roughly equal rates of White excess mortality differed widely in levels of Black mortality. Furthermore, in states like Wisconsin, researchers found no excess mortality among White people during the pandemic, but an additional 4.6 deaths per 10,000 among Black people. These findings emphasize the importance of geography and race for determining patterns of health disparities in the United States.[1]
- Chen et al. investigated cancer screening deficits across the United States during the COVID pandemic. Cancer screenings dropped precipitously during the onset of the pandemic (breast, –90.8 percent; colorectal, –79.3 percent; prostate, –63.4 percent). By July of 2020, most monthly screening rates had recovered to near pre-pandemic levels. The authors further documented regional variations in the decline and recovery of screening rates. The Northeast region experienced the sharpest declines in March, April, and May, while the recovery in screenings in June and July was slowest in the West. Prior to the pandemic, the data show significant disparities according to socioeconomic status (SES). During the pandemic, those in the highest SES quartiles experienced the largest declines in screening. In fact, during the peak of the pandemic, those from the highest SES groups had lower screening rates than those in the lowest groups. The authors provide evidence that the pandemic had the unintended consequence of narrowing screening disparities across SES groups. Their results also suggest that the screening deficit was larger for cancers

[1] Maria Polyakova, Victoria Udalova, Geoffrey Kocks, Katie Genadek, Keith Finlay, and Amy N. Finkelstein, "Racial Disparities in Excess All-Cause Mortality during the Early Covid-19 Pandemic Varied Substantially across States," *Health Affairs* 40, no. 2 (2021): 307–16, https://doi.org/10.1377/hlthaff.2020.02142.

which require a procedure (e.g., mammography and colonoscopy) as compared to prostate cancer (e.g., prostate-specific antigen testing). Furthermore, those with access to telehealth services were significantly more likely to receive a screening after adjusting for patient observables.[2]

- Patel et al. studied variation in telemedicine and outpatient care during the pandemic. Although total visit volume fell by 35 percent, 30.1 percent of all visits were delivered via telemedicine. The number of weekly visits delivered virtually rose by a factor of 23 compared to the pre-pandemic period. The authors found that adoption of telemedicine was lower among older patients, patients who reside in low income communities, and in rural counties. The authors attribute these differences to the "digital divide"—gaps in access to the internet and technology. Adoption varied significantly by specialty. Endocrinologists, gastroenterologists, neurologists, pain management physicians, psychiatrists, and cardiologists had half or more of the workforce using telemedicine during the pandemic. By contrast, optometrists, physical therapists, ophthalmologists, and orthopedic surgeons engaged the least with the technology. Conditions with the highest proportion of visits provided via telemedicine included mental illnesses such as depression (52.6 percent), bipolar disorder (55.0 percent), and anxiety (53.9 percent). Other conditions, such as hypertension and diabetes, had lower telemedicine use and saw a drop in total visit volume, suggesting that care management may have been deferred.[3]

Collectively, these studies highlight some of the inequities and variations across the U.S. health system. Equity is a pillar of the health benefit provided by the Military Health System (MHS). Research within the MHS has validated the importance of access and adequate resourcing as a means to reduce disparities—though they persist in several key areas such as mental health.[4] As reform efforts push more care to the civilian sector or technology enables new care models, policymakers must closely monitor health care markets to ensure that the MHS performs to enterprise standards of care. A consistent experience of high-quality care for all beneficiaries is paramount to the MHS mission.

Although the military's health benefit is uniform for all individuals, research has shown that civilian health systems exhibit large variations in care delivery. Recent literature stemming from the shocks of the COVID-19 pandemic suggest that variations in outcomes are inequities that could be prevented. As more health care shifts to civilian delivery channels, MHS beneficiaries will be increasingly subjected to both the good and bad of local health care markets. Consider further that military personnel rotate more frequently than the civilian population across both the direct and purchased care systems. Recent investment in health IT, such as MHS Genesis or virtual health, could reduce care fragmentation and improve continuity. (Some estimates suggest that increasingly fragmented care can lead to 77 percent higher costs.) However, much of the improvement will depend upon the interoperability of health care records between civilian and uniformed providers.[5] As the enterprise is restructured, it is essential to ensure that the quadruple aim of better care, better health, decreased costs, and improved readiness continues to apply to all beneficiaries.

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[2] Ronald C. Chen, Kevin Haynes, Simo Du, John Barron, and Aaron J. Katz, "Association of Cancer Screening Deficit in the United States with the COVID-19 Pandemic," *JAMA Oncology* 7, no. 6 (2021): 878–884, https://doi.org/10.1001/jamaoncol.2021.0884.

[3] Sadiq Y. Patel, Ateev Mehrotra, Haiden A. Huskamp, Lori Uscher-Pines, Ishani Ganguli, and Michael Lawrence Barnett, "Variation in Telemedicine Use and Outpatient Care During the COVID-19 Pandemic in the United States," *Health Affairs* 40, no. 2 (2021): 349–58, https://doi.org/10.1377/hlthaff.2020.01786.

[4] Jeff Hutchinson, Rachel Mack, Tracey Pérez Koehlmoos, and Patrick H. DeLeon, "Lessons for Health Equity: Military Medicine as a Window to Universal Health Insurance," *NAM Perspectives*, Discussion Paper, National Academy of Medicine, 2016, https://doi.org/10.31478/201611a.

[5] Lipika Samal, Patricia C. Dykes, Jeffrey O. Greenberg, Omar Hasan, Arjun K. Venkatesh, Lynn A. Volk, and David W. Bates, "Care Coordination Gaps Due to Lack of Interoperability in the United States: A Qualitative Study and Literature Review," *BMC Health Services Research* 16, no. 143 (2016), https://doi.org/10.1186/s12913-016-1373-y.

VETERANS AFFAIRS/MILITARY HEALTH SYSTEM LEGISLATIVE ROUNDUP (AS OF 5/29/21)

Jamie M. Lindly

Most recent defense-related activity by the congressional committee and subcommittee has considered fiscal year (FY) 2022 budgetary needs and priorities despite the lack of a full budget request from the administration. Given the delayed submission, the House Armed Services Committee may not mark up its version of the National Defense Authorization Act (NDAA) until September. The Senate Armed Services Committee expects to conduct its markup in June. Until then, lawmakers will work from topline summary estimates along with a few new policy initiatives submitted in April.

Recent testimony regarding veterans and defense medical issues includes:

Senate Veterans Affairs Committee Confirmation Hearing for Donald Remy as Deputy Secretary of the Department of Veterans Affairs (VA) (5/19/2021): Although the Office of the Deputy Secretary has been officially vacant since February 2020, Carolyn Clancy has been performing the duties in an acting role. Historically, the Deputy Secretary has been in charge of, among many other responsibilities, the Electronic Health Record Modernization program. Donald Remy is an Army veteran and most recently worked as the second-highest official at the National Collegiate Athletic Association.

Senate Armed Services Subcommittee on Personnel Programs (DoD) (5/12/2021): The subcommittee held its annual hearing on DoD personnel programs, despite the lack of a full FY 2022 budget request. This hearing historically helps the committee build its annual NDAA. Lernes Herbert, Assistant Secretary of Defense for Manpower and Reserve Affairs, discussed his organization's role in maintaining DoD operations during the pandemic. His organization also oversaw the rapid mobilization of more than 65,000 reserve component members to support the government's pandemic response while modifying operations to childcare centers and schools. Dr. Terry Adirim, Acting Assistant Secretary of Defense for Health Affairs, said the national response to the pandemic is the most significant issue facing the Military Health System (MHS). The MHS continues to provide critical support to the whole-of-government response to the crisis. Additionally, the MHS continues to implement reforms that started before the pandemic. It has resumed transitioning military treatment facilities to the Defense Health Agency (DHA) after a pause during the pandemic.

House Appropriations Defense Subcommittee on FY 2022 Army Priorities (5/05/2021): John Whitley, Acting Secretary of the Army, and General James McConville, Chief of Staff of the Army, testified regarding the Amy's FY 2022 budgetary needs and priorities. The subcommittee chair, Betty McCollum, indicated that appropriators "have some questions" on the effect of the Congressionally Directed Medical Research Programs, which fund high-risk, high-reward research on issues that affect warfighters. McCollum is particularly interested in the effect of that research on civilian health care. At the end of this hearing, McCollum said the subcommittee will hold a hearing on military health. In particular, it will review the Defense Health Agency's implementation of the NDAA reforms. She said the subcommittee does not want to fund "things that conflict with what is authorized."

House Appropriations Defense Subcommittee on the National Guard and Reserves (5/4/2021): General Daniel R. Hokanson, Chief of the National Guard Bureau, stated that today's National Guard is fully interoperable with the active duty component. This interoperability means the National Guard must also update facilities and needs more full-time support. However, Hokanson said that National Guard members face distractions that detract from their mission—one of which is health care. Premium-free health care for everyone who wears the Guard uniform is one of his top priorities. This is not only a strategic priority for readiness, he said, but is the right thing to do.

President Biden's Address to Congress (4/28/2021): President Biden addressed a joint session of Congress, largely discussing his proposed infrastructure package. He highlighted the proposed Advanced Research Projects Agency-Health (ARPA-H), for which $6.5 billion was requested in summary FY 2022 budget documents. Based upon the Defense Advanced Research Projects Agency (DARPA) model within the DoD, ARPA-H would focus on finding cures and treatments for chronic diseases such as diabetes, Alzheimer's, and cancer. The speed with which the COVID-19 vaccines were developed demonstrates what can be accomplished when scientific resources come together in a coordinated manner. ARPA-H would build upon lessons learned from the efforts to develop the COVID-19 vaccination.

Senate Veterans Affairs Appropriations Subcommittee on VA Telehealth (4/28/2021): Steve Lieberman, Acting Deputy Under Secretary for Health, Veterans Health Administration (VHA), testified that demand for telehealth skyrocketed during the pandemic across all settings, including urban areas. The VA responded by providing internet-enabled tablets to veterans who previously did not have access to technology. The department also set up a help line to aid veterans in using the devices and teach them how to access a telehealth visit. Even before the pandemic, the VA used telehealth to reach veterans in rural communities. In addition to care going directly to veterans in their homes, the ATLAS Project, created in concert with Walmart and Phillips, had started placing private spaces equipped with internet access and the technology needed to meet with VA providers via secure video connection in veteran service organization (VSO) facilities.

Senate Armed Services Committee Oversight Hearing on Management Challenges and Opportunities within DoD (4/27/2021): IDA's Peter Levine, former DoD Deputy Chief Management Officer, noted that even minor bureaucratic inefficiencies can cost millions of dollars. There are better ways of operating, but few shortcuts. Management reforms may not always yield savings; however, they may provide better support for the warfighter and better ways of operating. Levine said DoD needs better data systems and modernized skills within the workforce. To achieve these goals, he added, savings need to be reinvested in the management system.

Senate Appropriations Subcommittee on the Defense Health Program (DHP) (4/21/2021): Dr. Terry Adirim, Acting Assistant Secretary of Defense for Health Affairs, and three military Surgeons General testified on current military medical issues impacting the DHP. Dr. Adirim said the national response to COVID-19 is the most significant issue looming over all of their budgetary projections as costs attributable to the pandemic continue to accumulate. As of March 31, a mid-year review of the DHP projected a likely $1.8 billion increase in private sector costs to the DHP. The financial impact of military support to the Federal Emergency Management Agency (FEMA) missions, which are ongoing, remains to be assessed.

House Appropriations Subcommittee on MilCon and Veterans Affairs (4/15/2021): Denis McDonough, VA Secretary, and Jon Rychalski, Assistant VA Secretary for Management and Chief Financial Officer, presented their department's $113.1 billion budget request for FY 2022, which is an 8.2 percent increase over enacted levels in FY 2021. The request includes a $3.3 billion increase for medical care programs above the advance funding already approved by Congress.

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