Abstract

The Veterans Health Administration (VHA), the component agency of the Department of Veterans Affairs (VA) responsible for administering health care benefits to veterans and eligible beneficiaries, is facing chronic workforce shortages in clinical and nonclinical occupations at medical facilities across the nation. As a result, veterans and other beneficiaries who rely on the VA for their health care needs are experiencing diminished access to timely and quality health care services – putting their health and wellbeing at risk. This proposal details a legislative solution that offers increased educational and financial incentives to boost the recruitment and retention of those in sought-after occupations. An analysis of the proposal’s policy and political implications finds that its advantages outweigh its disadvantages and should therefore be made into law.

Advisor: Professor Paul J. Weinstein
With malice toward none; with charity for all; with firmness in the right, as God gives us to see the right, let us strive on to finish the work we are in; to bind up the nation's wounds; to care for him who shall have borne the battle, and for his widow, and his orphan...

Abraham Lincoln, *Second Inaugural Address*
Contents

I. Action Forcing Event .................................................................................................................... 1
II. Statement of the Problem ........................................................................................................... 1
III. History and Background .......................................................................................................... 8
IV. Policy Proposal ......................................................................................................................... 16
    A. Policy Authorization Tool ....................................................................................................... 17
    B. Policy Implementation Tool .................................................................................................... 18
V. Policy Analysis .......................................................................................................................... 21
    A. Effectiveness .......................................................................................................................... 21
    B. Efficiency ............................................................................................................................... 24
    C. Equity ................................................................................................................................... 25
    D. Technological and Administrative Capacity ........................................................................... 26
    E. Costs .................................................................................................................................... 27
VI. Political Analysis ..................................................................................................................... 29
    A. Stakeholder Perspectives ......................................................................................................... 29
    B. Public Opinion ...................................................................................................................... 34
VII. Recommendation .................................................................................................................... 35
Curriculum Vitae .......................................................................................................................... 38

Tables

Table 1: Utilization of VA Health Care Benefits ........................................................................... 2
Table 2: Financial impact of greater reliance on community care programs ............................... 6
Table 3: Workforce shortages by occupational series ................................................................... 7
Table 4: VCP authorizations from 2015 – 2018 based on eligibility group .................................... 10
Table 5: VA Appropriations History ............................................................................................... 14
MEMORANDUM

TO:    Senator Jon Tester (D-MT), Chair of the Senate Veterans’ Affairs Committee

FROM: Cory Sylvester

SUBJECT: Addressing Occupational Staffing Shortages in the Veterans Health Administration

DATE: May 13, 2022

I. Action Forcing Event

In September, the Department of Veterans Affairs (VA) Office of the Inspector General (OIG) released its annual report on occupational staffing shortages within the Veterans Health Administration (VHA). It found most VHA medical facilities are experiencing severe shortages in vital clinical and nonclinical occupations.¹

II. Statement of the Problem

The Veterans Health Administration (VHA) is the component agency of the Department of Veterans Affairs (VA) responsible for administering health care benefits to veterans and eligible beneficiaries. The problem this memorandum is going to address is the chronic shortage of clinical and nonclinical staff members at VA medical facilities across the nation. Veterans and their families who rely on the VA for their health care needs are seeing access to timely and quality health care services diminished. The effect is without the necessary staffing to manage and care for its patient population, the health and well-being of VA health care beneficiaries are put at risk.

As the largest integrated health care system in the United States, the VHA is responsible for serving about nine million enrolled veterans annually through its 1,293 health care facilities.² Its services

are as diverse as the needs of its patient population: from routine checkups and counseling services to
emergency care and assisted living. Family members and survivors of veterans can also qualify to receive
VA health care benefits under certain conditions – with over 297,000 such patients in fiscal year (FY)
2018.\(^3\) The agency’s operation of 171 VA Medical Centers and 1,112 outpatient clinics in all U.S. states
and territories equips it with the facilities necessary to meet the varying needs of its patient population.\(^4\)
The scope of its human capital, however, is less robust as the VHA has proven unable to effectively
recruit and retain a workforce capable of adequately staffing many of these facilities. That is despite
millions of beneficiaries relying on its services annually, as seen in table 1.

**Table 1: Utilization of VA Health Care Benefits**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Estimated U.S. Veteran Population</th>
<th>Total Enrollees in VA Health Care System</th>
<th>Total Unique Patients Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>21,973,000</td>
<td>9,110,000</td>
<td>6,600,000</td>
</tr>
<tr>
<td>2015</td>
<td>21,999,000</td>
<td>8,970,000</td>
<td>6,740,000</td>
</tr>
<tr>
<td>2016</td>
<td>21,681,000</td>
<td>9,050,000</td>
<td>6,260,000</td>
</tr>
<tr>
<td>2017</td>
<td>20,368,000</td>
<td>9,120,000</td>
<td>6,410,000</td>
</tr>
<tr>
<td>2018</td>
<td>19,998,799</td>
<td>9,170,000</td>
<td>6,340,000</td>
</tr>
<tr>
<td>2019</td>
<td>19,602,316</td>
<td>9,210,000</td>
<td>6,430,000</td>
</tr>
<tr>
<td>2020</td>
<td>19,209,704</td>
<td>9,160,000</td>
<td>6,450,000</td>
</tr>
<tr>
<td>2021</td>
<td>19,541,961</td>
<td>9,260,000</td>
<td>6,810,000</td>
</tr>
</tbody>
</table>


Occupational staffing shortages in the VHA are categorized in two different ways: severe staffing
shortages and position vacancies. For a position to be classified as a severe shortage, the Office of
Personnel Management (OPM) independently determines that the identified position meets criteria

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\(^3\) Office of Enterprise Integration, “Number of Veterans by Healthcare Priority Group: FY2000 to FY2018,” U.S Department of

\(^4\) U.S. Department of Veterans Affairs, “Veterans Health Administration.”
established by federal regulation.\(^5\) Only then are agency administrators granted direct-hire authority to make the burdensome hiring process for new employees more manageable. In FY21, VA medical facilities are reported to have had 2,152 occupational staffing shortages in 256 different professions classified as “severe.”\(^6\) Notable clinical occupations classified in this way include Nurse and Medical Officer – the VA’s designation for physicians and dentists.\(^7\)

Vacancies on the other hand refer to positions that are simply unoccupied for any given reason. At the end of FY21, the VHA had over 47,000 vacant positions – up almost six thousand vacancies from three years prior.\(^8\) Clinical occupations that are essential to delivering health care services like medical officers and nurses had 2,163 and 8,454 vacancies in FY21, respectively.\(^9\) That same year, other clinical occupations like psychologists had 820 vacancies with social workers claiming another 1,914 vacancies.\(^10\) The unique physical, mental, and social challenges veterans and their families face introduce extremely relevant factors to consider when contemplating what impact these kinds of vacancies can have.

\(^{5}\) 5 C.F.R. § 337.204, Severe Shortage of Candidates, states that:
(a) OPM will determine when a severe shortage of candidates exists for particular occupations, grades (or equivalent), and/or geographic locations. OPM may decide independently that such a shortage exists, or may make this decision in response to a written request from an agency.
(b) An agency when requesting direct-hire authority under this section, or OPM when deciding independently, must identify the position or positions that are difficult to fill and must provide supporting evidence that demonstrates the existence of a severe shortage of candidates with respect to the position(s). The evidence should include, as applicable, information about:
(1) The results of workforce planning and analysis;
(2) Employment trends including the local or national labor market;
(3) The existence of nationwide or geographic skills shortages;
(4) Agency efforts, including recruitment initiatives, use of other appointing authorities (e.g., schedule A, schedule B) and flexibilities, training and development programs tailored to the position(s), and an explanation of why these recruitment and training efforts have not been sufficient;
(5) The availability and quality of candidates;
(6) The desirability of the geographic location of the position(s);
(7) The desirability of the duties and/or work environment associated with the position(s); and
(8) Other pertinent information such as selective placement factors or other special requirements of the position, as well as agency use of hiring flexibilities such as recruitment or retention allowances or special salary rates.


\(^{7}\) Ibid, 12.


\(^{9}\) Ibid.

\(^{10}\) Ibid.
Nonclinical occupations are also experiencing severe shortages and sizable vacancies of their own. The Medical Support Assistance profession operates as the nexus between patients and the VA health care system. Specialists in this occupation are responsible for scheduling appointments, updating patient information, and coordinating outside care, among other critical responsibilities. In FY21, it was the most reported nonclinical occupation as having a severe shortage with a total of 5,167 vacancies nationwide. The impact of this shortage is intensified by the COVID-19 pandemic. By canceling, delaying, and moving 19.7 million appointments, the VHA will rely on its medical support assistants to coordinate with patients to get affected appointments rescheduled. Combined, the effects of severe staffing shortages and widespread position vacancies in clinical and nonclinical occupations jeopardize the wellbeing of patients as they risk not receiving the necessary treatments on time.

Wait times thresholds established under federal law are intended to safeguard patients from excessive delays in care and enable greater access to health care services. But using average wait times as a metric for health care accessibility is a mistaken and imprecise method of determination. For example, a veteran struggling with contemplations of suicide requires immediate care whereas a veteran in good health requesting periodic care can afford a relatively longer wait. Policies defining how these wait time parameters are calculated have even proven exceptionally vague and prone to

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scheduler error.\textsuperscript{16} This is evidenced by the department’s inability to confirm the accuracy or reliability of its own data on wait times for face-to-face appointments.\textsuperscript{17} In an effort to ensure veterans retain access to timely health care and support services, Congress authorized a number of community care programs requiring the VA to provide veterans access to non-VHA providers. Unfortunately, experience has shown that relying on external providers as a stopgap for the VHA is an inefficient mode of delivering care.

The costs for community-based care skyrocketed from $7.9 billion in 2014 to $17.6 billion in 2021 – consuming about twenty percent of the VHA’s total budget.\textsuperscript{18} The main reason for this hike is the growth in the number of veterans eligible to receive community-based care – up seventy-five percent from 2014 to reach 2.3 million in FY20, as seen in table 2.\textsuperscript{19} But greater funding for and utilization of community care programs is alone not a measure of better care. Community providers are not held to the same accessibility standards as the VHA. Veterans waited an average of forty-two days for community-based specialty appointments in FY20 with more than half of that time attributed to the VHA’s inefficient scheduling process.\textsuperscript{20} Some are even required to spend more time traveling to and from appointments, and when care is eventually administered in a community setting, it is difficult for the VHA to assess the quality of that care.\textsuperscript{21} Nonetheless, a recent survey found veterans who received care at non-VHA facilities were slightly more satisfied on measures related to appointments and wait times than those who received care at VHA facilities.\textsuperscript{22}

\textsuperscript{19} Ibid.
\textsuperscript{21} Congressional Budget Office, “The Veterans Community Care Program: Background and Early Effects.”
### Table 2: Financial impact of greater reliance on community care programs

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Eligible for Community Care</th>
<th>Total Cost of Community Care</th>
<th>Total Cost per Eligible Veteran</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>1,300,000</td>
<td>7,900,000</td>
<td>6,100,000</td>
</tr>
<tr>
<td>2015</td>
<td>1,400,000</td>
<td>10,500,000</td>
<td>7,500,000</td>
</tr>
<tr>
<td>2016</td>
<td>1,600,000</td>
<td>10,700,000</td>
<td>6,700,000</td>
</tr>
<tr>
<td>2017</td>
<td>1,600,000</td>
<td>12,500,000</td>
<td>7,800,000</td>
</tr>
<tr>
<td>2018</td>
<td>1,800,000</td>
<td>12,000,000</td>
<td>6,600,000</td>
</tr>
<tr>
<td>2019</td>
<td>2,100,000</td>
<td>13,200,000</td>
<td>6,300,000</td>
</tr>
<tr>
<td>2020</td>
<td>2,300,000</td>
<td>16,900,000</td>
<td>7,300,000</td>
</tr>
</tbody>
</table>


A complete evaluation of the problem would be incomplete without recognizing total VHA staffing numbers have grown over the last few years. Since FY18, the VHA has experienced an average annual employee growth rate of more than three percent.\(^{23,24}\) It has simultaneously decreased the number of occupational staffing shortages classified as “severe” by almost one thousand.\(^{25}\) And in spite of its staffing challenges, the agency maintains a lower turnover rates than comparably sized federal agencies and the healthcare industry overall.\(^{26}\) However, the perception that progress is being made against chronic workforce shortages cannot obscure the fact that staffing shortages actually show no real sign of improvement.

Net staffing increases are the result of annual budget appropriations for new full-time equivalent (FTE) employees that increase employment numbers in some occupations and leave others

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\(^{24}\) Averaging the VHA’s growth rate from FY18 to FY20 yielded an average annual growth rate of 3.05%. This total excludes additional temporary employees funded by the CARES Act of 2020.

\(^{25}\) U.S. Department of Veterans Affairs, Office of the Inspector General, OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages, Fiscal Year 2021, 10.

\(^{26}\) Ibid, 3.
untouched. VA health care facilities can also have vacancies in some occupations that have not yet been categorized as severe shortages. And while certain occupations experienced net increases in staffing, others that are critical to patient health care outcomes continue to struggle with sizeable vacancies and severe shortages, as seen in table 3. Medical officers and nurses, for example, have been classified as having severe shortages every year since 2014.\textsuperscript{27} A series of causal factors like noncompetitive salaries, recruitment challenges, turnover, and a scarcity of qualified applicants has played a significant role in these staffing problems.\textsuperscript{28} Many of which mirror those faced by the rest of the health care industry.\textsuperscript{29}

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|c|c|}
\hline
Fiscal Year & Social Sciences (0100) & Medical and Dental (0600) & All Occupations \\
\hline
 & Vacancies & Facilities Reporting Severe Shortage & Vacancies & Facilities Reporting Severe Shortage & Vacancies & Number of Severe Shortages \\
\hline
2018 & 2,880 & 58\% & 23,376 & 99\% & 40,914 & 3,068 \\
2019 & 2,985 & 47\% & 24,668 & 94\% & 43,410 & 2,685 \\
2020 & 3,294 & 47\% & 24,985 & 87\% & 43,101 & 2,430 \\
2021 & 2,978 & 60\% & 22,115 & 90\% & 35,841 & 2,152 \\
\hline
\end{tabular}
\caption{Workforce shortages by occupational series}
\end{table}


\textit{Notes:} The occupational series code OPM derives for Social Sciences (0100) encompasses occupations like Psychology (0180) and Social Work (0185), among others. The occupational series code for Medical and Dental (0600) designates occupations like Medical Officer (0602), Nurse (0610), and Medical Support Assistance (0679), among others. Further, the above vacancy calculations are averages of the vacancies reported quarterly at all VA medical facilities. FY18 vacancy data covers only Q3 and after due to the implementation timeline of Section 505 of the MISSION Act.

\textsuperscript{27} Ibid.
\textsuperscript{29} Office of Human Resources & Administration/Operations, Security, and Preparedness, “VA MISSION Act, Section 505 Annual Report - 2021.”
Veterans and their families as a result find themselves between a rock and a hard place. They are at the mercy of the VHA’s unreliable processes and the inefficiency of community-based care. Ultimately though, these issues derive from occupational staffing shortages at VHA facilities across the nation. And to ensure the millions of VA health care beneficiaries receive the timely and quality care they deserve, we must confront the issue with the understanding that it is not only an ethical dilemma, but an economic one as well.

III. History and Background

The mission of the Department of Veterans Affairs (VA) is to fulfill President Lincoln’s promise “To care for him who shall have borne the battle, and for his widow, and his orphan.” The agency is responsible for serving and honoring America’s veterans by managing earned benefits through one of its three component agencies: the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), and the Veterans Health Administration (VHA). The VA is also charged with improving the nation’s preparedness for public emergencies by supporting local, state, and federal agencies in responding to such events. And in the time for the VA to transform into the second largest federal department, its mission remains unchanged. Recent memory reminds us, however, that the agency has not always lived up to that standard.

Whistleblowers in 2014 exposed that VA medical facilities nationwide were intentionally falsifying patient wait times to create the illusion established wait time performance standards were being met. Official wait lists created the impression patients were being seen within the fourteen-day target window whereas unofficial lists concealed the true extent of wait times. In the Phoenix VA Health Care System where the whistleblower reports originated, an investigation found a sample of 226

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veterans waited an average of 115 days for primary care appointments.\textsuperscript{33} The falsified data on official waitlist suggested they would only have waited twenty-four days.\textsuperscript{34} The exact number of veterans who died waiting for care remains disputed, but VA leadership acknowledges veterans did die as a result of excessive wait times.\textsuperscript{35} A contributing factor that led to widespread fabrication of wait times – outside of the incentives created by facilities meeting the arbitrary fourteen day target – was the VHA’s shortage of clinical and nonclinical staff.

At that time, the VHA was experiencing a surge of veterans from the wars in Iraq and Afghanistan on top of an aging Vietnam veteran population. In the three years prior to the scandal, the VHA experienced a fifty percent increase in primary care appointments while the number of primary care doctors increased by only nine percent.\textsuperscript{36} A White House report published not long after the whistleblowers came public revealed the extent of this workforce shortage. It found clinical staff like doctors and nurses and nonclinical administrative staff were insufficient to appropriately coordinate and accommodate growing patient needs.\textsuperscript{37}

In response, bipartisan efforts in Congress led to President Obama signing the Veterans Access, Choice, and Accountability Act of 2014 (“Choice Act”) into law after passing the Senate 91-3.\textsuperscript{38} The law, as currently amended, requires an annual review by the VA Inspector General (IG) to determine at least five clinical and five nonclinical VHA occupations calculated as having the largest staffing shortages.\textsuperscript{39} It

\begin{itemize}
  \item[\textsuperscript{33}] Ibid, iii.
  \item[\textsuperscript{34}] Ibid.
\end{itemize}
provided the Secretary the authority to recruit and directly appoint employees into these identified occupations supported by $5 billion in new mandatory funding. The $10 billion Veterans Choice Program (VCP) was also established to temporarily expand patient access to non-VHA providers when local VHA facilities proved unable to provide such care. As table 4 shows, millions of veterans soon qualified to receive community-based care based on one of the law’s several eligibility factors. Noticeable implementation issues with the Choice Act soon followed, however, along with congressional efforts to remedy those issues – ultimately fueling the shift in how veterans’ health care is administered.

Table 4: VCP authorizations from 2015 – 2018 based on eligibility group

<table>
<thead>
<tr>
<th></th>
<th>Wait-time Eligible</th>
<th>Mileage Eligible</th>
<th>Resides in State/Territory Without VA Medical Facility</th>
<th>Unusual/Excessive Travel Burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Veterans</td>
<td>4,035,497</td>
<td>646,410</td>
<td>180,699</td>
<td>5,672</td>
</tr>
</tbody>
</table>


The Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 required the VA consolidate all community care programs into a single program – something that is accomplished only a few years later with the passage of the MISSION Act. A subsequent amendment to the Choice Act later eliminated the VCP’s sunset date, allowing it to expend all remaining funds on community care.

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40 Ibid.
42 The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146) determines a veteran eligible to receive VA health care is eligible for the VCP if any of the following apply:
(1) Attempts, or has attempted, to schedule an appointment for the receipt of hospital care or medical services, but is unable to schedule an appointment within the wait-time goals of the VHA for the furnishing of such care or services;
(2) Resides more than 40 miles from the medical facility of the Department, including a community-based outpatient clinic, that is closest to the residence of the veteran;
(3) resides in a location, other than a location in Guam, American Samoa, or the Republic of the Philippines, that is 40 miles or less from a medical facility of the Department, and is required to travel by air, boat, or ferry to reach each medical facility; or faces an unusual or excessive burden in accessing each medical facility due to geographical challenges, as determined by the Secretary;
(4) Resides in a state without, or more than 20 miles from, a medical facility of the department that provides: hospital care, emergency medical services, and surgical care rated by the Secretary as having a surgical complexity of standard.
for those who needed it.  Unfortunately, the increased reliance on community-based care did not
address accessibility concerns for all patients. Some veterans continued to experience wait time similar
to or longer than those at VA medical facilities. Congress nonetheless continued to affirm the VCP,
recognizing the greater flexibility it offered veterans and moved to reshape the VHA’s existing workforce
structures and processes.

The $2.1 billion the VA Choice and Quality Employment Act of 2017 infused into the VCP
extended the life of the program before all funds were set to be expended. Equipped with the
resources to continue augmenting the VA health care system for the near future, the law also furnished
the VA with new departmental powers aimed at improving the VA’s recruitment and retention efforts.
Some of these initiatives include more professional development opportunities for managers alongside
additional promotional tracks for technical specialists. It also included the ability for managers to rehire
former employees at one grade higher. The law even expanded the scope of annual reports on VHA
occupational shortages and created a database to track certain department vacancies to enable greater
transparency of the workforce – allowing other efforts to be better targeted. The law also sponsored
new recruitment and retention training for hiring managers so they can best employ these new
provisions. An initial draft of the bill failed in the House of Representatives after some Veterans Service
Organizations (VSOs) voiced their opposition to its lack of focus and investment in the modernization of
the VA.  

45 Sharon Silas and A. Nicole Clowers, “Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation
48 Nicole Ogrysko, “Last minute Veterans Choice funding bill filled with key VA hiring flexibilities,” Federal News Network, July
That sentiment was well understood the following year with the passage of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018. On top of moving all community care from mandatory to discretionary spending and consolidating them all into the more navigable Veterans Community Care Program (VCCP), the MISSION Act also invested heavily in the VHA workforce. The sum of all bonuses that can be paid to VA employees increased by twenty-six percent to $290 million in FY21 with at least $20 million earmarked for recruitment, relocation, and retention purposes.49 The Specialty Education Loan Repayment Program (SELRP) was established to offer loan repayment options to recent medical school graduates with a maximum value of $160,000. In exchange, graduates agree to one year of full-time employment with the VHA for every $40,000 received.50 The program, one of the many tools used to increase labor market competitiveness for such candidates, is scheduled to be implemented in 2021 with an initial cohort of one hundred graduates.51

The MISSION Act also amended the VA’s Education Debt Reduction Program (EDRP) to increase the maximum amount of debt that can be reduced from $120,000 to $200,000 in hard-to-recruit and hard-to-retain specialties.52 Since the program’s creation in 1998, it has been used to hire and retain over twenty thousand clinical providers with 1,987 new awards made in 2020.53 Those aiming to serve in Title 38 and Hybrid Title 38 disciplines can receive full tuition scholarships covering authorized fees and expenses thorough the Health Professionals Scholarship Program (HPSP).54 Since 2016, the VA has awarded 502 scholarships for students in various clinical positions.55 In 2020, due to the MISSION Act

50 Ibid.
53 Office of Budget, “FY 2022 Budget Submission: Medical Programs and Information Technology Programs.”
55 Office of Budget, “FY 2022 Budget Submission: Medical Programs and Information Technology Programs.”
increasing the minimum number of scholarships awarded to medical students, fifty-four out of the required fifty were awarded. In exchange, all scholarship recipients agree to serve in VA medical facilities in their clinical disciplines for eighteen months for every year funded.

The Employee Incentive Scholarship Program (EISP) predates the MISSION Act and targets current VA employees interested in filling positions in occupations that can be hard to recruit and hard to retain. The program offers scholarships covering the equivalent of three years of full-time coursework totaling a maximum of $40,117.37 in tuition costs for undergraduate and graduate programs. The program gives priority to those studying clinical disciplines experiencing shortages, entering a mental health occupation, or agreeing to serve in a rural VA healthcare facility. Upon completion, employees agree to serve in one of the many clinical and nonclinical positions listed in 38 U.S. Code § 7401 that can be difficult to fill for one to three years. The program has sponsored 2,442 scholarship recipients since its inception in 2000.

The purpose of these and other incentive programs is to ensure the VHA remains a competitive employer for health care professionals amidst a national shortage. Health care professions are estimated to lack a combined 3.2 million workers in 2026 with physicians accounting for up to 120,000 of those. Even with access to these incentive resources, however, the VHA has proved unable to effectively compete with the greater resources offered by the rest of the medical industry. Without enough medical professionals for its patient population, the VHA continues to rely on community-based

56 Ibid.
57 U.S. Department of Veterans Affairs, “Health Professions Scholarship Program.”
58 U.S. Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1426.01(1) (Washington, DC, 2019), A-1.
60 Ibid.
62 Office of Budget, “FY 2022 Budget Submission: Medical Programs and Information Technology Programs.”
care for its patients. And while some improvements have been made since 2014, occupational shortages in clinical and nonclinical areas still exist and continue to cause disruptions. Efforts to reshape the VA medical system and revive its workforce have consequently required ever increasing appropriations from Congress.

Guaranteeing veterans access to quality health care remains one of the few policy issues to receive broad bipartisan support. The VA saw its percentage distribution of the federal discretionary budget increase by two percent from FY11 to reach 6.5 percent in FY21 – a timeframe spanning three different administrations. Table 5 breaks down how the VA’s discretionary and mandatory funding, authorized annually by the Military Construction, Veterans Affairs, And Related Agencies appropriations bills, has steadily increased to more than double over the last decade. It also breaks down the role growing VHA appropriations have on total departmental appropriations. Efforts to reform and modernize the agency with these funds have led to trust in the VHA reaching an all-time high in FY20 among veterans. Contrary to conventional wisdom though, the influx of additional resources over the last decade has failed to yield any significant improvements to VHA’s workforce shortages.

Table 5: VA Appropriations History

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total VA Budget Appropriations</th>
<th>Total VHA Budget Appropriations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$120,958,652,000</td>
<td>$51,392,784,000</td>
</tr>
<tr>
<td>2012</td>
<td>$122,226,272,000</td>
<td>$54,022,287,000</td>
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<tr>
<td>2013</td>
<td>$134,117,429,000</td>
<td>$56,189,031,000</td>
</tr>
<tr>
<td>2014</td>
<td>$165,482,068,000</td>
<td>$58,031,656,000</td>
</tr>
<tr>
<td>2015</td>
<td>$159,579,614,000</td>
<td>$59,619,422,000</td>
</tr>
<tr>
<td>2016</td>
<td>$163,209,993,000</td>
<td>$62,270,373,000</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Total Appropriations</th>
<th>Medical Care Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$178,858,716,000</td>
<td>$68,713,669,000</td>
</tr>
<tr>
<td>2018</td>
<td>$193,302,535,000</td>
<td>$74,150,481,000</td>
</tr>
<tr>
<td>2019</td>
<td>$197,519,893,000</td>
<td>$77,825,538,000</td>
</tr>
<tr>
<td>2020</td>
<td>$236,226,916,000</td>
<td>$100,672,916,000</td>
</tr>
<tr>
<td>2021</td>
<td>$258,579,237,000</td>
<td>$109,422,363,000</td>
</tr>
</tbody>
</table>

**Table 5 (continued)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Appropriations</th>
<th>Medical Care Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>$258,579,237,000</td>
<td>$109,422,363,000</td>
</tr>
</tbody>
</table>


*Notes:* Total appropriations include the $24.4 billion mandatory funds appropriated under the Choice Act. It also includes the $19.6 billion in discretionary funds appropriated under the CARES Act. Total appropriations do not include payments from veterans and private insurers into the Medical Care Collection Fund (MCCF).

Some have used the concerns about the VHA’s accessibility as an opportunity to capitalize on greater privatization of the VA medical system. Republicans have historically favored using the agency’s additional appropriations to offer more community care options for veterans.68 President Trump, for example, championed the MISSION Act and its expansion of privatized care under the VCCP. He also favored the law’s provision to establish an Asset and Infrastructure Review (AIR) Commission to decide which VHA facilities require modernization or realignment based on the Secretary’s recommendations.69 A nonpartisan commission could be of great value to the VHA to ensure the most efficient use of VHA resources given changing veteran demographics. But a commission composed of personnel committed to the privatization of the VA medical system could restrict the VHA’s ability to provide care and force a greater reliance on community providers. President Biden has not yet nominated any of the nine AIR commissioners almost a year after the deadline.70

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Others are concerned the expansion of community-based care is putting into question the sustainability of the VA’s growing budget. Democrats in general counter the Republican inclination to expand privatized care, believing what was once intended to supplement the VHA has begun to replace it. Democrats instead favor using the VA’s resources to hire more medical professionals to ensure it can care for as many veterans as it can in-house.71 Rep. Wasserman Schultz, chairman of the House Appropriations Military Construction and Veterans Affairs Subcommittee, considers the seemingly limitless expansion of the VCCP to be a zero-sum game: more resources for community-based health care means less funding for VHA-based health care.72 Veterans seem to overwhelmingly agree, preferring to improve the existing VA health care system over redirecting funds to the VCCP.73

The VA’s recognition of its own chronic workforce shortages has yielded little results despite access to record resources. A review of the department’s own strategic plan highlights its intention to take several steps to attract qualified candidates.74 The details of these plans, however, are left exceptionally vague and neglect addressing employee retention issues.75 Providing solutions to these key issues requires an actionable level of specificity that will guide policymakers on how to best assist the agency and the population it serves.

IV. Policy Proposal

The VHA Hiring, Employment, and Retention Overhaul (HERO) Act will authorize the agency sufficient financial incentives over the next ten years to eliminate all severe occupational staffing shortages and reduce all vacancies by half. Earmarking new resources for the Veterans Health Administration (VHA) to better compete and incentivize prospective and current employees will ease

71 Jennifer Steinhauer and Dave Philips, “V.A. Seeks to Redirect Billions of Dollars into Private Care.”
75 Ibid, 37.
workforce shortages over the short to medium term – providing veterans greater access to health care and creating additional savings on community care. To realize these policy goals, the ensuing subsections lay out the policy authorization apparatus and the details of its implementation.

A. Policy Authorization Tool

To address the chronic workforce shortages in the VHA, the HERO Act will expand existing scholarship programs, loan repayment programs, and bonuses for identified occupations to boost the agency’s appeal in the competitive labor market. Authorizing these policy changes can only be done by law. Under the authority granted to Congress in Article 1, Section 8 of the U.S. Constitution, it is granted the “power of the purse,” that is, the authority to authorize government spending.76 Thereby the budget authority and appropriations required by the HERO Act can only be provided by the legislative branch. And it is Congress and only Congress that can expand the scope of these incentives by amending the applicable federal laws.

The VA MISSION Act of 2018 authorized the most recent and most significant changes to VA incentive programs to aid in its recruitment and retention of healthcare professionals. The programs in question and the modifications to be authorized to those programs under the HERO Act include:

- **The Health Professional Scholarship Program (HPSP):** Increase the minimum number of scholarships awarded annually to students training to be employed as physicians and dentists from fifty to 250. Only when staffing shortages in these positions fall below five hundred, increase the number of scholarships awarded annually from not less than ten percent of the staffing shortage to fifteen percent. Additionally, increase the number of scholarships awarded annually to other clinical specialties to equal no less than 250 or fifteen percent of the staffing shortage – whichever is greater.

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♦ **The Education Debt Reduction Program (EDRP):** Increase the maximum total of debt that may be reduced from $200,000 to $250,000 and increase the maximum amount that may be paid each year from $40,000 to $50,000.

♦ **The Specialty Education Loan Repayment Program (SELRP):** Increase the maximum loan repayment amount from $160,000 over four years to $250,000 over five years and increase the maximum amount to be paid annually from $40,000 to $50,000.

♦ **The Employee Incentive Scholarship Program (EISP):** Increase the program’s funding threshold to cover the equivalent of four years of full-time undergraduate and graduate level coursework totaling a maximum of $53,476.45 in tuition costs.

5 U.S. Code § 5753 and § 5754 pertain to federal limitations on the amount employees can be paid in recruitment, relocation, and retention bonuses. The HERO Act will amend these limitations and create an exception for VHA employees as such:

♦ **Bonuses for Recruitment, Relocation, and Retention:** Increase the maximum percentage used to calculate bonuses from twenty-five percent to fifty percent of basic pay for all VHA clinical and nonclinical employees.

### B. Policy Implementation Tool

The VA and its offices of primary responsibility will implement and oversee the amended forms of these policies just as is done for their current iterations. The Office of Human Capital Management will maintain responsibility for the various educational incentive programs and will implement the modifications to the Health Professional Scholarship Program, Education Debt Reduction Program, Specialty Education Loan Repayment Program, and the Employee Incentive Scholarship Program within one year of enactment of the HERO Act. The Office of Finance will similarly maintain payroll responsibilities and will implement the changes to recruitment, relocation, and retention bonuses for eligible employees within thirty days of enactment. Minimizing the delay in applying these changes
reduces the time qualified candidates and employees go without access to better incentives. This thereby increases prospects of filling short-staffed positions and maintaining its qualified workforce to expand the VHA’s ability to provide care.

Funding for the HERO Act is estimated to cost a total of $20.7 billion over ten years.\textsuperscript{77} The total cost of the proposed legislation is calculated by using the existing cost analysis equations for each program and introducing the modified variables accordingly. The cost breakdown is divided into the five distinct incentive programs that make up the HERO Act:

- **Cost of the New Health Professional Scholarship Program (HPSP):** The total cost of the modified HPSP is estimated to be $1.1 billion over ten years with an average annual cost of $114 million. This is an over four hundred percent increase from FY20 costs.\textsuperscript{78} This estimate is based on awarding five hundred new scholarships each year for ten years – 250 for physicians and dentists and 250 for other eligible clinical specialties – at an average individual award amount of $67,000 per year for four years.\textsuperscript{79}

- **Cost of the New Education Debt Reduction Program (EDRP):** The total cost of the modified EDRP is estimated to be $880 million over ten years with an average annual cost of $88 million. This is an increase of twenty-five percent over FY20 costs due to the twenty-five percent increase in maximum payments for the running average of two thousand new program participants annually.\textsuperscript{80}

- **Cost of the New Specialty Education Loan Repayment Program (SELRP):** The total cost of the modified SELRP is estimated to be $200 million over ten years with an average annual cost of $20 million. This is almost eighty-eight percent more than initial cost

\textsuperscript{77} Total cost is calculated by adding the estimated ten years costs for each incentive program: $1.1 billion for the HPSP; $880 million for the EDRP; $200 million for the SELRP; $54.5 million for the EISP; and $18.5 billion for recruitment, relocation, and retention bonuses. Cost estimations are not adjusted for inflation.

\textsuperscript{78} Office of Budget, “FY 2022 Budget Submission: Medical Programs and Information Technology Programs.”

\textsuperscript{79} Ibid.

\textsuperscript{80} Ibid.
estimates for the original program. This estimate is based on the $50,000 annual cost of reimbursing each program participant with the number of program participants increasing by one hundred each year to reach a maximum of five hundred participants.

♦ **Cost of the New Employee Incentive Scholarship Program (EISP):** The total cost of the modified EISP is estimated to be $54.5 million over ten years with an average annual cost of $5.5 million. This is an increase of thirty-three percent over FY20 costs due to the thirty-three percent increase in the maximum payment allowed for each participant – totaling $53,476.45 over four years with 120 new participants each year.

♦ **Cost of the Recruitment, Relocation, and Retention Bonus Modifications:** The total cost of increasing bonus rates from twenty-five percent to fifty percent of basic pay for all VHA employees is estimated to cost $18.5 billion over ten years with an average annual cost of $1.9 billion.

Similar incentive programs for clinical and nonclinical professionals have been implemented in other areas of the federal government. The military departments of the Department of Defense (DoD) offer their own Health Professions Scholarship Programs (HSPS) to attract medical professionals to serve in their ranks – albeit with different service requirements. The Indian Health Service (IHS) also offers its own loan repayment programs with additional opportunities available for students and professionals through its parent agency – the Department of Health and Human Services (HHS). The IHS even makes use of its own recruitment, relocation, and retention bonuses authorized under 5 U.S. Code § 5753 and

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81 Ibid.
82 Ibid.
84 Cost estimates are based on FY21 staffing levels – totaling 350,790 FTE at a cost of $37,009,983,000 – where each FTE receives one such bonus within ten years.
§ 5754 to incentivize current and prospective employees to accept positions considered to be hard to fill.

The HERO Act targets students, recent graduates, medical professionals, and current and former employees to fill many of the open positions and provide quality health care services to patients – all without easing eligibility standards. The service commitments tied to many of the programs ensure the VHA and taxpayers receive their return on investment and recipients get the chance to explore a career with the VHA that may not have otherwise taken place. The Office of Public Affairs in conjunction with the offices of primary responsibility shall develop campaigns to target these audiences to ensure the VHA has access to enough interested and qualified individuals.

V. Policy Analysis

A comprehensive understanding of the HERO Act and its policy implications requires a thorough and objective analysis using a series of evaluative tools to identify the advantages and disadvantages of the proposal. The framework is based on factors that assess the anticipated policy processes, impacts, and results as they relate to the initially conceptualized goals of the HERO Act. Only then is a reasonable judgement of the policy and its goals of achieving zero severe occupational staffing shortages and reducing vacancies by half over the next ten years possible.

A. Effectiveness

The targeted and measured approach of the HERO Act’s incentive offerings is likely to fulfill its policy goals based on an analysis of existing programs within the Veterans Health Administration (VHA) and the federal government. Since its inception in 2016, the Health Professional Scholarship Program (HPSP) has awarded 763 scholarships and placed 291 clinicians of varying disciplines at Veterans Affairs (VA) medical facilities across the nations. The comparatively smaller scope of the existing program has consequently been an insignificant player in the VHA’s onboarding of approximately 22,000 clinical

86 Office of Budget, “FY 2023 Budget Submission: Medical Programs and Information Technology Programs.”
employees in short-staffed occupations since 2017.87 Rural VA medical facilities nonetheless benefit considerably from the HPSP given the mobility clause within the scholarship’s contract requiring signatories to move and serve where needed.

For their part, the Education Debt Reduction Program (EDRP) and Employee Incentive Scholarship Program (EISP) have contributed to recruiting and retaining more than forty thousand employees in difficult-to-fill clinical positions since their inceptions more than two decades ago.88 And while the MISSION Act’s Specialty Education Loan Repayment Program (SELRP) has limited available information, other governmental loan repayment programs for medical professionals have proved resoundingly successful. The National Health Services Corps (NHSC) loan repayment programs, for example, have fortified its workforce with 15,656 recipient clinicians currently employed.89 Relying exclusively on incentive programs can have downsides, however, as they ignore the underlying problems that might be preventing an organization from realizing its desired outcome.90

Psychologist Frederick Herzberg suggests incentive programs like the ones proposed are extrinsic motivators (what he calls KITAs) that yield only temporary compliance.91 “Since KITA results only in short-term movement, it is safe to predict that the cost of these programs will increase steadily and new varieties will be developed as old positive KITAs reach their satiation points.”92 He argues employee motivation and utilization is best maximized when work is enriched through intrinsic motivators like achievement, recognition, and responsibility.93 Compiling the findings of studies researching employee motivation, Herzberg concludes “of all the factors contributing to job satisfaction,

87 Ibid.
88 Ibid.
92 Ibid.
93 Ibid.
81 percent were motivators” while sixty-nine percent of those leading to job dissatisfaction involved extrinsic motivators.\textsuperscript{94} For the VHA, that can mean the HERO Act doesn’t solve its employment shortages, but only band-aids them. Recipients of its incentives may not work smarter or harder or grow more committed and may only remain if the incentives are satisfying enough. Even so, extrinsic motivators have a history of fulfilling their stated purposes. Results from the 2017 Stay in VA (SIVA) trial program showed increased retention bonuses offered to nurses at a VA Medical Center with a fourteen percent attrition rate reduced turnover by fifty-two percent.\textsuperscript{95}

The Department of Defense’s ongoing efforts to address pilot shortages in the Air Force offers an insightful case study into the government’s use of bonuses to attract highly skilled specialists in a competitive labor market. As competition with the civilian aviation industry soared over the last decade, the DoD began offering pilots bonuses of up to $420,000 accruing a maximum service commitment of twelve-years.\textsuperscript{96} The rate of acceptance of these bonuses “have ranged from 30 to 40 percent during periods of high airline hiring and from 60 to 70 percent during periods of low airline hiring.”\textsuperscript{97} At a time when labor competition in the medical industry remains comparatively high and flush with cash, the VHA can expect similar rates of acceptance than if a cooler labor market dominated.

Taken together, the HERO Act’s incentive offerings with varying degrees of success will lead to the VHA recruiting and retaining the desired number of capable clinical and nonclinical staff members to achieve its policy objectives. Assuming the VHA’s average annual turnover rate of 9.6 percent continues,

\begin{itemize}
\item \textsuperscript{94} Ibid.
\item \textsuperscript{95} Office of Human Resources & Administration/Operations, Security, and Preparedness, “VA Section 505 Data – Annual Report – 2021.”
\end{itemize}
the policy is forecasted to recruit and/or retain an estimated 119,723 additional employees over ten years – well above the 35,841 vacancies and 2,152 severe shortages reported in FY21.98,99

B. Efficiency

The competitiveness of the healthcare industry makes the recruitment and retention of clinical and nonclinical employees highly inefficient. In labor markets experiencing equilibrium, conditions are perfectly efficient as the established market-clearing wage equals the value of the marginal product of labor.100 In contrast, the medical industry’s labor market is plagued by too many employers chasing too few employees – too much demand and not enough supply. The industry, in accordance with economic principle, has responded by increasing not only wages but other incentives when higher wages prove either insufficient or too expensive. Wages for primary care physicians have increased an average of more than three percent each year for the last five years.101 But more than half of physicians still feel undercompensated.102 So in the battle for healthcare talent, wages and incentives will only continue to climb until a greater supply of workers emerges (or America’s demand for health care declines). The HERO Act takes the most efficient route to address an inefficient problem.

Most of the programs offered by the HERO Act are expected to have immediate effects on staffing numbers where employees can begin providing services relatively shortly. Once the EDRP, SELRP, and bonuses are awarded, current employees continue in their jobs while prospective employees are effectively ready to begin once officially onboarded. Only when the HPSP and EISP are awarded do

99 Calculation based on the HSPS, EDRP, SELRP, EISP recruiting and/or retaining 500, 2000, 100, and 120 employees each year for ten years, respectively, at a 9.6% turnover rate. Also used is the estimation that bonuses will help recruit and/or retain 30% of all FY21 FTEs at a 9.6% turnover rate (estimation based on the acceptance rate of bonuses offered to Air Force pilots in comparable labor market conditions).
recipients have to complete schooling along with the appropriate follow-on trainings and certifications. Even with the delayed return on investment for these approximately 620 additional professionals each year, the proposal’s ten-year $20.7 billion price tag offers a more economically efficient course to improve veteran health care than current processes.

The VA’s FY23 budget request of $28.4 billion for community care programs for 2.3 million veterans will generate costs that average over $12,000 per veteran. Comparatively, the same request which estimates a total of 9.2 million veterans enrolled in VA health care is forecasted to cost an average of just over $10,000 per enrollee – even when the $2.1 billion annual cost of the HERO Act is factored in. The inefficiency becomes even more potent when considering over three-quarters of veterans who qualify for community-based care live in rural areas and efforts to increase their health care access have proven inadequate since these areas are also underserved by community providers.

C. Equity

The accessibility of VA health care affects beneficiaries differently since some rely on it for care more than others. In 2019, a VHA survey found about eighty percent of those enrolled in the VA health care system possessed at least one other form of public or private health care coverage. That same year, all VA beneficiaries contributed to an estimated 38.3 percent aggregate reliance on the VA for their health care needs. But those enrollees who rely exclusively on the VA health care system are more

104 Calculation based on the cost of community care programs requested for FY23 ($28.5 billion) divided by the estimated number of veterans eligible for community care (2.3 million) – based on FY21 eligibility numbers, the last year of available information.
105 Office of Budget, “FY 2023 Budget in Brief.”
106 Calculation based on the budget request for medical care in FY23 ($118.7 billion) minus the amount requested for community care ($28.5 billion). The projected annual cost of the HERO Act ($2.1 billion) is then added to the difference ($90.3 billion). The sum ($92.4 billion) is then divided by the estimated number of veterans to be enrolled in the VA medical system in FY23 (9.2 million).
108 Office of Budget, “FY 2023 Budget Submission: Medical Programs and Information Technology Programs.”
109 Ibid.
disadvantaged by a limited access to VA health care than those with alternative options. Fulfilling the HERO Act’s policy objective thereby plays a significant role in equalizing health care access for all veterans – whether the VA is their main source of care or not.

A disadvantage of attracting more of the limited supply of health care workers in the U.S. to the VHA can lead to a zero-sum game in the medical industry’s labor market. Employing more such workers with the VHA limits the private sector’s access to these same resources and creates an uneven distribution of medical professionals. Studies show the coming decade will see an increase in demand for these professionals that continues to outpace supply – meaning current efforts to incentivize talent are not the last. So, while health care access for veterans is equalized, the accessibility for Americans outside the VA health care system becomes comparatively more disadvantaged.

D. Technological and Administrative Capacity

The VA’s antiquated information technology (IT) systems and persistent cybersecurity challenges have been noted for years by watchdogs and jeopardize its ability to oversee the HERO Act. A Government Accountability Office (GAO) report identifies two critical IT systems in the VA’s inventory that are both over fifty years old. One such program, the Personnel and Accounted Integrated Data (PAID) system, is used to maintain accountability for employees in three major areas: time and attendance, master records, and education tracking. Questions quickly arise on the ability of this system to account for and keep up with the influx new employee information expected over the coming decade. Even efforts to modernize its IT systems, like those targeting the development of an electronic health record system, have been plagued by serious issues. Internal reviews have uncovered patient data for things like allergies, medications, and immunizations frequently contained errors. And the

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subsequent efforts to manually fix patient records found to contain errors occasionally ended up causing more mistakes than were fixed.113

The challenges of these and other IT systems are further complicated by the VA’s exposure to cybersecurity threats. Since 2016, the GAO has warned about the VA’s lack of an effective strategy for implementing IT security controls.114 Without adequate protection, the Personally Identifiable Information (PII) of patients and employees and its ability to conduct day-to-day operations are put at risk. Even with the $4.9 billion the VA plans to invest in its IT infrastructure in FY23, the HERO Act and its stakeholders will have to accept the risks associated with agency’s inadequate IT infrastructure until such risks are eventually addressed.115

Another drawback is the VA does not currently have the administrative staff necessary to manage existing educational incentive programs. The department’s FY23 budget request identifies the need for fourteen new full-time equivalent (FTE) employees to support the HPSP, EDRP, and ERSP.116 Given the HERO Act’s proposed expansion of these programs and the SELRP above existing levels, the need for additional administrative FTEs will have to be identified in future budget submissions. Fortunately, in the time from the HERO Act’s authorization to its implementation, additional budget requests will be submitted that can include this information.

E. Costs

The HERO Act is disadvantaged by the fact that it does not identify new revenue stream to offset its financial costs. Even though it has been shown to boost the VHA’s overall economic efficiency, lacking a counterbalancing source of funding means the money will have to come from somewhere else: either from deficits or other programs. The financial costs as a result will be most severely felt when the HERO

113 Ibid.
115 Office of Budget, “FY 2023 Budget in Brief.”
116 Office of Budget, “FY 2023 Budget Submission: Medical Programs and Information Technology Programs.”
Act is operating concurrently to the community care programs it aims to reduce. Veterans will continue to make use of community care programs until workforce shortages are sufficiently addressed and access to VHA facilities improves.

Even considering its financial cost, the HERO Act is responsible for fueling more favorable health care outcomes for patients. A recent study shows comparable elderly veteran populations in emergencies have a 46 percent reduction in 28-day morality when treated at VA medical facilities compared to private hospitals that accept Medicare benefits.\textsuperscript{117} These results are consistent with previous research that concluded VA hospitals outperform private hospitals in most parts of the country.\textsuperscript{118} Such findings help shed light on why most veterans prefer receiving their care through the VA.\textsuperscript{119}

Some might perceive the proposal’s targeting of medical students and young professionals who lack the necessary working experience as a disadvantage. Flooding the VA medical system with green employees can overwhelm existing onboarding processes. These new employees will all be earning their experience on the job where VA medical beneficiaries stand to be the ones most impacted by this lack of professional experience. Simply expecting healthier employee numbers to equate to better access and thereby better patient outcomes is a false correlation. The key is to have more good employees.

The VA recognizes this and is why its Health Professions Education (HPE) programs play a leading role in developing a competent health care workforce for itself and the nation.\textsuperscript{120} Its training portfolio “is designed to augment VA workforce and align with Veteran’s healthcare needs,” helping


\textsuperscript{120} Office of Budget, “FY 2023 Budget Submission: Medical Programs and Information Technology Programs.”
minimize the risks posed by junior medical professionals.\textsuperscript{121} Because the VHA is responsible for training over 124,000 clinical trainees annually in more than one hundred different health care programs, it is more than capable of absorbing the additional employees enticed by these incentive programs.\textsuperscript{122} VA health care providers, whether new or experienced, must also maintain the appropriate credentials. It is “the first step in patient safety and ensure health care providers meet the clinical qualifications required to provide quality care.”\textsuperscript{123} No organization in the health care industry can sustain itself without onboarding new and effectively trained professionals to offset turnover.

VI. Political Analysis

Appreciating where key stakeholders and the general public stand on the HERO Act is critical to making sense of and navigating the political consequences. Accurately identifying what these viewpoints are facilitates the development of strategies that maximize the political benefits of the policy and mend any of its political costs.

A. Stakeholder Perspectives

Veterans Service Organizations (VSOs) are organizations that offer a wide range of assistance and support services to veterans, servicemembers, dependents, and survivors.\textsuperscript{124} As of 2018, America had about eighteen million veterans – providing the more than one hundred VA-recognized VSOs a strong and consistent constituent base.\textsuperscript{125,126} The political throw weight VSOs have come to enjoy is rooted in “their large membership and the degree to which they command public respect.”\textsuperscript{127} Congress’ reliance on VSOs to help draft pieces of veteran-centric legislation such as the Choice Act and the

\textsuperscript{121} Ibid, 212.
\textsuperscript{122} Ibid.
\textsuperscript{123} U.S. Department of Veterans Affairs, Veterans Health Administration, \textit{VHA Directive 1100.20} (Washington, DC, 2021), T-1.
MISSION Act puts on display the degree of this influence. The largest of these organizations are known informally as “the Big Six:” American Legion, Veterans of Foreign Wars, Paralyzed Veterans of America, American Veterans, Disabled American Veterans, and Vietnam Veterans of America.  

A number of these advocacy groups come together annually to publish *The Independent Budget* (IB) – a collection of budgetary and appropriations recommendations for the Department of Veterans Affairs (VA). Advocating for greater access to the Veterans Health Administration (VHA), the FY23 IB calls for sustained aggressive hiring practices at a cost of $1.8 billion to fill thirty-three percent of its clinical and nonclinical vacancies. In a recent interview, Joy Ilem of Disabled American Veterans says that to continue providing veterans quality benefits amidst the pandemic, the VA requires the money to “recruit, hire, and retain” good employees. The American Legion, America’s largest VSO with 2.3 million members, lists VA health care modernization as one of its top legislative priorities. By supporting legislation aimed at making data about VA “staffing/vacancy information publicly available,” the American Legion and other VSOs hope greater accountability and transparency can enable more effective advocacy.

Traditionally, VSOs spend relatively little directly lobbying Capitol Hill. For example, the American Legion and Veterans of Foreign Wars (VFW) spend about $40,000 to $50,000 per year lobbying. Instead, VSOs of the twenty-first century emphasize building grassroots support for veterans issues in the communities they serve. The only notable exception being Concerned Veterans

128 Ibid.
130 Ibid.
132 Veterans Experience Office, “Traditional Veterans Service Organizations.”
136 Jennifer Steinhauer, “Veterans’ Groups Compete with Each Other, and Struggle with the V.A.”
of America (CVA) – a Koch brothers backed VSO in favor of privatizing the VA health care system – which has spent $52 million supporting political campaigns nationwide since its founding.\textsuperscript{137} Most veterans conversely prefer improving the VA health care system over simply expanding community care options with many VSOs combating the privatization of VA health care.\textsuperscript{138} Supporting the HERO Act will align you closer to VSOs in their fight to improve the VA health care system.

It will also gain the support of many academic institutions and their students, led by the Association of American Medical Colleges (AAMC). The AAMC is the primary organization dedicated to representing 171 medical schools in the U.S. and Canada, more than four hundred teaching hospitals that include VA medical centers, 191,000 faculty members, 149,000 resident physicians, and ninety-five thousand medical students.\textsuperscript{139} The AAMC is committed to making medical education more accessible, and lists expanding federal student aid and federally administered graduate medical training as some of its top priorities.\textsuperscript{140} In the 2020 cycle, it contributed $4.4 million to lobbying – making it one of the year’s top lobbyists.\textsuperscript{141}

Notable opponents to the HERO Act include trade associations in the healthcare industry that represent the interests of private health care providers. One such organization, the American Hospital Association (AHA), consists of almost five thousand hospitals and health care systems along with forty-three thousand individual members.\textsuperscript{142} In its current year advocacy agenda, the AHA notes the need for close cooperation with the VA “as they implement the next generation of comprehensive community care for veterans.”\textsuperscript{143} It also notes the need for members to authorize and improve recruitment and

\textsuperscript{137} Lawrence Korb, “Caring for U.S. Veterans: A Plan for 2020.”
\textsuperscript{138} Ibid.
\textsuperscript{142} American Hospital Association, “About the AHA,” accessed April 24, 2022, https://www.aha.org/about.
retention programs for various health care professions. Last year, the AHA spent more than $25 million lobbying policymakers – the second most of any industry group. A recent study also found the healthcare sector to be the most successful industry at influencing policymakers, spending $677 million in 2021 – the most of any industry.

The American Medical Association (AMA) is another such organization strongly supporting the expansion of VA community care programs. Even though the AMA recognizes America’s growing shortage of physicians, its support for legislation aimed at increasing graduate medical education positions “at teaching hospitals and in community settings” lacks clarity for VA medical facilities – unlike the AAMC. Considering the HERO Act aims at increasing the VHA’s care capacity, it will inevitably draw more patients once eligible for community-based care back to VA health care facilities. Consequently, by treating fewer veterans on the VA’s dime, community-based providers will see their bottom lines impacted. And with additional competition introduced into the labor market by this policy, industry members will find themselves having to offer more incentives to stay competitive.

In their opposition to the policy, industry associations can leverage their deep pockets to influence decisionmakers. The health care sector alone contributed $1.4 million to your reelection campaigns out of the $22 million raised from 2017 to 2022 – ranking it seventh among other sectors. A zero-sum game inevitably results in choosing how to navigate the HERO Act: back it and earn the political support of VSOs and lose support of some health care associations or oppose it and continue

144 Ibid.
147 Open Secrets, “Sector Profile: Health.”
receiving their financial support at the cost of veterans’ support. In contemplating this decision, it is important to note though not all contributors will be impacted the same way by the policy. The pharmaceutical industry, for example, will continue to see their products purchased and prescribed to veterans whether they receive community-based care or not. Continuing to leverage those health care associations not directly impacted by the HERO Act can help mitigate any political costs incurred.

In general, veterans’ issues tend to receive broad bipartisan support on Capitol Hill. In November, President Biden signed four bipartisan bills into law designed to equalize and improve benefits available to veterans and their families. Veterans health care is no different, witnessed by the overhauls to VA health care in the last decade championed by both major parties. Bipartisanship on the issue falters on the issue of how the VA should increase health care accessibility and quality for beneficiaries: more investment in community-based care or VHA-based care. The Republican Party’s 2020 platform (which is the same as 2016) advocates for expanding community care options due to the VHA’s backlogs and occupational shortages. More recently, Rep Mike Bost (R-IL), the Ranking Member of the House Committee on Veterans’ Affairs, remarked how the VHA must work to boost its recruitment and retention to address ongoing staffing shortages. Not through new investments into the VHA, but instead by making “the most efficient use of existing resources.”

Democrats on the other hand openly support greater investments directly into the VA health care system. The party’s 2020 platform commits to not privatizing the VA, but to “modernize VA facilities and bolster funding to the VA as part of a nationwide infrastructure plan.”

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FY23 budget request is ten percent more than the enacted FY22 version with significant investments in the VHA workforce. Absent any agreement on how to best approach improving the VA health care system, supporting the HERO Act will align you closer to the Democratic Party.

One alternative to the HERO Act is following the Republican playbook of investing more into community-based care. That option is not recommended due to the political backlash expected and the irrationality of the policy. As discussed, the growing costs of community-based care are expected to outpace the cost of the HERO Act. VHA providers are also shown to deliver better health care outcomes and are held more accountable than community providers, helping explain why many veterans prefer to receive VHA-based care. Maintaining the status quo is also not a reasonable alternative. To address the ethical and fiscal defects of the current system, investment in the VHA workforce is needed to cure its biggest limiting factor and yield results as soon as possible.

B. Public Opinion

The American public’s continued ability and willingness to recognize the hardships veterans of all generations face has encouraged the federal government to offer better forms of assistance. Between 1946 and 2011, Gallup and Pew asked veterans whether they received all the help they thought they needed from the federal government, with a steady majority answering in the affirmative each time. The public was asked about its own perception of veterans’ benefits – to much different results. About one third believed benefits were not adequate in 1947 with that number growing to fifty-eight percent in 2012. More recently, in 2021, a survey found eighty-seven percent of Americans

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159 Ibid.
support doing more for veterans with seventy-six percent believing the government does a fair/poor job.\textsuperscript{160}

Findings such as these underscore the fact “Strong majorities support a variety of government measures to improve the lives of veterans, and almost no one thinks spending on vets should be decreased.”\textsuperscript{161} The same survey from 2021 found that over ninety-two percent of public respondents favored free medical care for veterans for physical and mental health ailments originating from military service.\textsuperscript{162} Whether these services come from the VHA or community-based providers is irrelevant – public opinion dictates veterans receive their earned benefits. It is up to policymakers to honor the preferences of veterans in a fiscally responsible manner.

The demographics of Montana’s population are also important to note. The U.S. Census Bureau found that as of 2015, twelve percent of Montana’s population were veterans, the second highest of any state ranking only behind Alaska.\textsuperscript{163} With 94,000 veterans calling Montana home along with nineteen VA facilities, at least 94,000 voters can be considered direct stakeholders in the HERO Act.\textsuperscript{164} That on top the 752,538 registered voters in Montana can be expected to harbor the same respect and desire to care for veterans as the rest of the American public.\textsuperscript{165} Supporting the HERO Act will align you closer with public opinion.

\textbf{VII. Recommendation}

The chronic staffing shortages that plague the Veterans Health Administration (VHA) continue to impact the health and wellness of veterans and their families. In what began as an ethical challenge,


\textsuperscript{161} Roper Center, “A Hero’s Welcome: The American Public and Attitudes Towards Veterans.”

\textsuperscript{162} Jessie Coe et al. \textit{American Perspectives on Veterans} (Santa Monica: RAND Corporation, 2021), 15.


policies implemented to remedy the situation have become fiscally unsustainable with no sign of better health care access for most beneficiaries. Without addressing the root cause of agency’s employment shortages – competition with the health care industry for limited candidates – the Department of Veterans Affairs (VA) will be ill equipped to fulfill President Lincoln’s promise. The status quo only guarantees questionable health care accessibility for millions of veterans at increasingly higher costs for taxpayers. Therefore, I recommend you support the HERO Act in its approach to equip the VHA with the resources necessary to address the principal cause of its occupational staffing shortages.

The HERO Act is not without drawbacks, most notably its $20 billion price tag over ten years. And because the proposal does not identify a new source of revenue, that money is going to have to come from somewhere – either from other programs or debt. It can be difficult to justify an even larger budget to fund the HERO Act when the VA is already enjoying record high funding. This concern is compounded by the fact that money for the HERO Act will have to be appropriated concurrently to the vast sums going to the community care programs it aims to reduce. A successful HERO Act will not yield immediate results, meaning more money will have to be spent before results are ever seen. Only then will the VHA be equipped to handle more patients in more specialties in less time. But even without a new revenue stream and large up-front costs, the bill is not destined to just cost money. It is an investment that will save money.

Caring for the 9.2 million veterans enrolled in the VA medical system will cost about $2,000 less per patient than the 2.3 million veterans using community care programs in FY23. And that is factoring in the HERO Act’s annual costs. While not all veterans making use of community care are willing or able to receive care at VHA facilities, providing those facilities with the workforce capable of providing for those who do is a significant step towards greater efficiency. The advantages offered by the HERO Act far outweigh its drawbacks.
History shows the federal government’s use of educational and financial incentives to attract highly skilled and sought-after employees is an effective means of combating employment shortages. Similar or identical programs at the Department of Defense, Health and Human Services, and VA have all proven themselves as successful and worthy investments. Boosting the VHA’s capacity for care and veterans’ access to care will equalize health care for all veterans. Not all veterans are impacted by the VHA’s shortages equally: veterans who rely solely on the VA for their health care needs don’t have the same alternatives as those with other insurance options. Some detractors may try to claim the increased bonuses offered as part of the Act will create the same corrupt climate as productivity bonuses did before the VHA’s 2014 scandal. The bonuses offered here, however, are categorically different as they are not productivity incentives, but ones for employment.

What must also be considered a deciding factor is the political weight behind investment in the VHA’s workforce. The political strength and influence of Veterans Service Organizations (VSOs) is not unfamiliar on Capitol Hill and as Chair of the Senate Veterans’ Affairs Committee, that strength is something that can be wielded in support of or against you. And even though you politically benefit from industry groups against the HERO Act, their comparatively small political contributions are bested by those generated by VSOs and medical education advocacy groups. The robust public support for veterans’ issues – especially veterans’ health care – in Montana and across the country is the final measure needed to confidently make an informed decision on the matter. I recommend you support the HERO Act to provide the means necessary to get our veterans the health care they deserve.
Curriculum Vitae

Cory Sylvester was born on June 9, 1996, in a suburb of Minnesota’s Twin Cities. He received his Bachelor of Arts in Business Administration from the University of St. Thomas in 2018 where he also earned his commission as an officer in the United States Air Force. Upon entering active duty, Cory completed training as a Nuclear and Missile Operations Officer and has since served in various operational and leadership positions earning multiple awards and commendations. He currently serves as an instructor for the LGM-30G Minuteman ICBM responsible for conducting academic and procedural training to ensure missile crew combat mission readiness. Cory is pursuing his Master of Arts in Public Management from Johns Hopkins University. He and his wife currently reside in Fort Collins, Colorado.