

**U.S. DEPARTMENT OF VETERANS' AFFAIRS
BUDGET REQUEST FOR FISCAL YEAR 2021**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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THURSDAY, FEBRUARY 27, 2020

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

The committee met, pursuant to notice, at 10:06 a.m., in room 210, House Visitors Center, Hon. Mark Takano (chairman of the committee) presiding.

Present: Representatives Takano, Brownley, Lamb, Levin, Brindisi, Rose, Pappas, Luria, Lee, Cunningham, Cisneros, Peterson, Sablan, Allred, Underwood, Roe, Bilirakis, Bost, Dunn, Bergman, Banks, Barr, Meuser, Watkins, Roy, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good morning. I call this hearing to order. A quorum is present.

Pursuant to Committee Rule 4 and House Rule XI, Clause 2, the chair may postpone further proceedings today and, without objection, the chair is authorized to declare a recess at any time.

Thank you, Secretary Wilkie, and your team for coming in to discuss the Department of Veterans Affairs budget request for Fiscal Year 2021. I also want to welcome our Veterans Service Organization (VSO) partners and look forward to hearing their views on our second panel.

Despite a requested 12-percent increase for VA's budget, I am deeply concerned this request ignores a much worse reality. This budget could lead to less food on the plates of struggling veteran families, no new housing vouchers for homeless veterans, and millions of veterans cutoff from key support programs. This 12-percent increase comes at the expense of significant cuts to critical domestic programs that veterans, especially those in crisis, depend on.

One point seven million veterans rely on Medicaid, but the President's budget would cut Medicaid by \$900 billion over the next 10 years. More than half of all veterans, approximately 9.3 million, rely on Medicare, but the President's budget would cut Medicare by \$500 billion over the next 10 years. Over 600,000 disabled veterans receive Social Security disability insurance a year, but the President's budget would cut Social Security benefits by at least \$24 billion. Nearly 1.3 million veterans live in households that participate in Supplemental Nutrition Assistance Program (SNAP), but the President's budget would cut SNAP by \$182 billion over the next 10 years. As of January 2019, there are 37,085 homeless veterans

and Department of Housing and Urban Developments (HUD's) rental assistance program would be cut by \$3.5 billion.

Additionally, the President proposed we slash almost \$700 million from the Center for Disease Control 2021 budget, the very agency on the front lines of the coronavirus response. Meanwhile, the Centers for Disease Control and Prevention (CDC) warned this week that there will likely be an outbreak of the coronavirus in the United States. The President requested a separate, supplemental response, but it is wholly inadequate and would actually raid the funds set aside for other life-threatening public health emergencies such as Ebola.

As the Nation responds to the coronavirus outbreak, we cannot forget our veterans. They will not be immune to this virus and, under VA's fourth mission, it is our responsibility to ensure VA is prepared. While I am pleased that this budget places significant investments in mental health care for veterans, a top priority for this committee, VA and the President—it is a top priority for this committee, VA, and the President, I am alarmed that resources are directed outside the VA into grant programs and the PREVENTS Task Force instead of being used to explicitly support veterans in crisis. As demand for VA mental health services continues to grow, we need to ensure VA programs are fully funded before this money is directed elsewhere.

I also emphasized in my remarks yesterday during the VSO hearing that I have made reducing veteran suicide my No. 1 priority and that is why the committee adopted a comprehensive, evidence-based framework to address the crisis of veteran suicide from every angle. Our approach takes into account multiple factors that could reduce veteran suicide, everything from lowering economic burdens to increasing access to care and improving crisis intervention for those at higher risk.

While funding has increased to reduce veteran homelessness, a factor that may lead to suicide, HUD faces significant cuts itself and for the fourth straight year HUD has zeroed out any new U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) vouchers, and I can tell you from experience representing my constituents in Riverside County that these vouchers are essential to ending homelessness. This program is a partnership between VA and HUD, and HUD provides the housing assistance and VA provides the key wraparound services. It does no good to only fund the VA services side of the partnership, veterans need housing provided by these HUD vouchers and for the—while we need these both to work for HUD-VASH, the program, to reduce veteran homelessness. Both VA and HUD need to be fully funded.

VA also increased its budget for gender-specific women veterans health care by 9 percent, but its funding for hiring and training the clinicians and staff who run the women's health program is far below what is needed according to the independent budget. The chronic under-resourcing of women's health at VA is an indication of the greater cultural issue of fully valuing women veterans and, if we want to have an honest conversation about suicide prevention, we need to address the culture of sexual violence against women at VA. Currently, VA does not even require mandatory by-

stander intervention training for all employees, contractors, vendors, and volunteers.

When Congress passed the MISSION Act in June 2018, tens of thousands of pre-9/11 veterans and their caregivers won a hard-fought battle for equality with their post-9/11 counterparts, a battle that took nearly a decade; however, VA's inability to meet congressionally mandated time lines has prevented these veterans and their families from accessing these services.

The budget requests \$1.19 billion for 2021, which is a \$485 million increase over last year's funding levels for the program. However, to date, VA has not released the regulations outlining changes to the caregiver program that were authorized by the MISSION Act. Without finalized regulations published, it is unclear how accurate VA's budget request for this program is, potentially further breaking an already broken promise.

The budget also requests additional employees to help with Blue Water Navy claims processing, but ignores funding for claims and treatment for other herbicide-exposed veterans despite extensive and credible evidence that their conditions are related to Agent Orange exposure. I sent a letter to President Trump with 77 of my House colleagues to ensure four diseases were added to the presumptions list. Senate Democrats and VSO leaders have called for the same inclusion, but there has been no response from this Administration. I was disappointed to see that the Secretary did not even address this injustice in his prepared remarks. That and the fact that this budget does not request any funding for these additional diseases signals that this Administration is not making progress on this matter. These veterans have already waited too long.

Despite all of these increases, the President's budget would hurt veterans by slashing programs that ensure essential needs are met. When you consider it in its entirety, this budget is a cruel document that cuts housing, food security, health care, and key assistance that millions of veterans depend on.

Now, instead, I suggest that we have to work together to ensure that we can keep the promises that we have made to our veterans and ensure that our budget reflects humane values.

That concludes my opening remarks and, with that, I recognize Dr. Roe for 5 minutes for his opening statement.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Mr. Chairman. I think it is fair to say that you and I view this budget through a very different set of lenses.

When I came to Congress 11 years ago, the Department of Veterans Affairs' budget was \$97.7 billion, which supported just over 260,000 employees, and that is medical benefits and cemeteries and health care, as it does today. Today, we are examining a VA budget request that totals \$243.3 billion, almost a quarter of a trillion dollars, that would fund more than 400,000 VA employees, much larger than the U.S. Navy. That is an increase of \$145 billion, almost 150 percent, and 140,000 full-time employees, approximately 65 percent.

Since 2017 alone, VA's budget has grown by \$60 billion and VA's staff has grown by more than 50,000, and as you can see in the

graphs behind me here. Increased government spending certainly does not always equate to improved government services, sometimes quite the opposite. However, this tremendous investment in our Nation's veterans has more than paid off under this President. Not only is VA more well-funded, well-staffed than ever before, but it is unquestionable that veterans are better served. I hear it every day when I go home now. Compared to President Trump's first day in office, veterans today have more access to care, more choices in care, more control over their care than any other time in history. Veteran unemployment has reached near-record lows. Veterans are expressing significantly greater trust in the VA. Veterans are able to use their GI Bill benefits whenever they choose. Veterans are getting their appeals for disability compensation decided faster and more efficiently.

I remember we were in the Cannon Building in my first term, General Shenseki said we have a million backlog disability claims, we have 100,000 homeless veterans, and I applaud him for trying to get this number down. Dr. Lawrence, hopefully, in his remarks, will tell us where that is. It is rather remarkable what has happened for disability claims. Veterans are getting more support during their transition out of the military, veterans are able to go to urgent care clinics in their neighborhoods instead of traveling to VA hospitals for things like just a cold or a sprained ankle or whatever, something minor.

Veterans who served in the Blue Water Navy during the Vietnam war are finally receiving the benefits they have earned. Let me tell you, that was the work of bipartisan on both sides of the aisle, they got that done. It was not easy, it was fully paid for, it is done; we should take a victory lap for that.

Fewer veterans are homeless. A hundred thousand when I came here, which was unconscionable, now down to the numbers somewhere in the 30,000's. By the way, there are 10,000 unused HUD-VASH vouchers, 10,000 right now that have not been used that should be. Fewer veterans are dependent on opioids, which is great. The widow tax that financially penalized surviving spouses of disabled veterans has been repealed. Caregivers of seriously injured pre-9/11—that is my generation—veterans will soon receive the same support that caregivers of post-9/11 veterans receive.

VA has begun the process of modernizing its electronic health record and achieving true interoperability with the Department of Defense. VA has become one of the six best places to work in the Federal Government from number 17, the worst. Poor-performing employees are being held accountable. Whistleblowers have additional avenues to report concerns and be protected from retaliation.

I could go on and on and on. Just look at the charts behind me, which are available on the minority website. That is certainly not to say our work is over, it is far from it, it will never be completely done, but it is to say that the staunchest critics of this President are being disingenuous when they claim that he has not put veterans first and that his policies have not led to clear improvements in the lives of veterans and their families, as I believe the previous Administration did.

As for the work still ahead of us, many of the accomplishments I have mentioned earlier, which are listed in the graphs behind me,

will require the ongoing leadership and oversight of this committee and our partners in VA and in the veterans service organizations.

I remain particularly concerned about the State of VA medical facilities across the country, which is why I fought so hard to include the Asset and Infrastructure Review (AIR) as part of the MISSION Act 2 years ago. AIR is the most transformational, yet least discussed, aspect of the MISSION Act. It has the potential to permanently change the way VA delivers care across the country and help veterans, particularly those in rural, remote, and minority communities who are not being well served by the crumbling infrastructure that exists throughout the VA health care system.

Just yesterday I had a State veterans service officer in my office, along with their organization, from Montana. A very, very rural area. The newest facility in the State is a hospital that has half their beds are full and many veterans have travel miles and miles. We can look at that new hospital and partner with them to help the local community and help veterans. That State veterans service officer told me that they opened an office in their community right there where they worked so veterans would not have to drive 65 miles for mental health services one way and 65 miles back and many times in a snowstorm. It is used 5 days a week. Those are the things we need to be doing for our veterans and we are.

Veterans in the 21st century deserve to have access to the high-quality care close to their homes in facilities that were designed and built to provide modern medicine, not the ones who are relics of years long ago and that exist in neighborhoods where veterans no longer live.

Change is not easy, I got that, especially for a health care system as antiquated and entrenched as VA, but AIR presents an incredible opportunity to preserve the VA for future generations of veterans. We cannot let this pass us by.

But perhaps no greater challenge remains than preventing veteran suicide. I completely agree with the chair on what his primary object is, to help lower that, I could not agree more. If the number of veterans who died by their own hands every year in—that died in combat instead, there would be a worldwide outcry and calls for action, as we are doing now with the coronavirus. We should be doing that with the 6,000 veterans and active duty who commit suicide each other. Those men and women are dying on a different battlefield and far too long their deaths have been accepted as inevitable, they are not. Incredible efforts have been invested in ending this crisis, but those efforts have failed and they will continue to fail until we are collectively brave enough to challenge the status quo, connect with the majority of veterans who are outside the VA's reach, and provide them with the support and care that they need where they are without requiring them to come to us first just because that is how we have always done it. I know that this President and this Secretary agree with me on that point and I appreciate their leadership and their commitment to doing so.

Clearly, great progress has been made. You could be forgiven for not being aware of just how much, because when it comes to veterans we seldom talk about their triumphs as loudly as we talk about their trials. That does a real injustice to them and is a narrative that I would like to overturn in my final year on this com-

mittee. For now I will simply say that whenever we, as a grateful nation, have invested in the brave men and women who fought in the defense of our freedoms it has paid dividends not just for them, but also for our country and our future. This budget is a wise investment in our future and I wholeheartedly support it.

I thank all of our witnesses for being here and, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Ranking Member Dr. Roe.

Appearing for us today is Hon. Robert Wilkie, Secretary of United States Department of Veterans Affairs. We have Dr. Richard Stone, Executive in Charge of the Veterans Health Administration; Dr. Paul Lawrence, Under Secretary for Benefits; Mr. Jon Rychalski, Assistant Secretary of Management and Chief Financial Officer. We look forward to hearing your testimony today.

Secretary Wilkie, I now recognize you to present your statement.

STATEMENT OF ROBERT WILKIE

Secretary WILKIE. Thank you, Mr. Chairman, and thank you, Dr. Roe. I appreciate, again, this is my second time as Secretary, I made an appearance talking about programs as the acting, sitting under the picture of an old friend of mine from many years ago, Walter Jones, the late Walter Jones, Sr., so it is good to be back.

I want to pick up on something that Dr. Roe said that I am in wholehearted agreement with. The Department of Veterans Affairs looks nothing like it did a few years ago. A few years ago, there were incredible stories of failures and excuses. Today, we are not only leading the country in innovation and modernized systems, but, above all, we have satisfied veterans.

VA has implemented the most far-reaching transformational programs since the GI Bill was signed by President Roosevelt in June 1944. We have put in place just in the last year and a half the Colmery Act, the MISSION Act, the Blue Water Navy Act. That is a record of achievement that I think most Federal departments would be proud of. What makes me most proud is our ability to make these sorts of changes without missing a beat when it comes to serving America's veterans.

In the last few years, I have heard a great deal of debate about the MISSION Act being a gateway to privatization. Well, last year, we completed almost 60 million internal appointments in the Department of Veterans Affairs, that is an increase in 1.7 million internal appointments even as we sent 2.8 million to outside care under MISSION. Ninety percent of our veterans across the country, according to the surveys, trust the care they get at VA. Surveys continue to show that we are competitive with the private sector on wait times and quality. Much of this improvement has happened because we have brought back accountability to VA and released more than 8,000 staff who were not performing.

As Dr. Roe said, 2 years ago we were sitting at 17 out of 17 in terms of best places to work; today, we are at sixth. One of the reasons for that, other than accountability, is what we call the high-reliability organization. I have made it clear that VA is a bottom-up organization where people at every end of the strata have a say in how their work is performed, they have a say in how their leaders perform their work, and I think that has gone a long way to

improving morale amongst our staff and, if morale amongst our staff is high, the care for veterans is much better.

In addition, our staff continues to innovate and improve the quality of veterans' lives. It was the Department of Veterans Affairs that brought America the first cardiac pacemaker and the first liver transplant, now we are leading the way on cancer treatment. Precision oncology promises new ways to attack cancer by not attacking the patient. In Northern California, in Palo Alto, we just put on line one of the first 5G hospitals in the United States that will allow us to deliver telesurgery services remotely to veterans across the country. It is telehealth, as Dr. Roe pointed out, that will allow us to reach those veterans, particularly those veterans in the Western United States and in the Pacific Islands, where we can diagnose patients remotely without forcing them to encounter long journeys.

Now, we have several challenges on the horizon, as the chairman pointed out. Next week, I expect the caregiver regulations to be published in the Federal Register, fulfilling a promise that I made to Senator Murray that the program itself would not change until we actually had regulations in place and an IT system that is ready to go for all veterans.

I take this personally. Some of you have heard me talk about my experiences growing up as the son of a combat soldier from Vietnam. My mother was a caregiver. My father passed away about a year and a half ago and when I last saw my mother at the end of last year she did tell me about the suffering that he engaged in, which we think was from chemical poisoning, which is why I place particular emphasis, as the chairman does, on getting the presumptions for Agent Orange right. I have seen it happen in my family. That is a promise to you that I am doing everything as diligently as I can to make sure that we do not go through what those veterans went through so many years ago and that we set the pace for the future for those veterans who have come since Vietnam.

We are closer on the electronic health records. I did inform the committee that I delayed the rollout by a few weeks because we were not ready to train on a system that was not 100 percent ready for those who would be using it. I think this is also an example of the change in morale at VA. I gave the practitioners on the ground in eastern Washington the power to tell me, Mr. Secretary, it is not ready to go, and I was not going to have thousands and thousands of practitioners practice on a system that was not ready.

I am very gratified at the progress that we have made. I think we are in a much better place than many of the private sector hospitals were who engaged in this development many years ago; the Mayo Clinic, Children's Hospital. I think we are in a very good place to finally deliver that long-gone promise that when a young man or woman comes in to a military entrance processing station they have an electronic record that is built for the rest of their lives, so people like my father never carry around an 800-page record for the decades that they lived after they left military service.

As the chairman noted, in a few weeks we will present the PREVENTS Task Force report for a nationwide plan to work with

State, local, and tribal groups to identify veterans who are at risk of suicide.

In addition to what the chairman said, that I take very seriously, we are offering more services to women than ever. Women like what they see, more and more are enrolling at VA. As of last year, 41 percent of all American women veterans are enrolled at VA, that is compared with 48 percent of all male veterans. Last year, 84 percent of all women veterans surveyed said they trusted the care that they received VA. We have a zero tolerance policy for all of that behavior that makes women uncomfortable.

I will leave you with one more initiative that we are pursuing that is important to me. I have been accused of being an amateur historian and I plead guilty. The most spiritual speech ever given by an American President was the second inaugural address of Abraham Lincoln that would have been presented 150 years ago next week, where he laid out his vision for what was then known as the Veterans Bureau, I have asked that that address be placed in all of our cemeteries to remind us of that sacred bond that the country has with those who have shared, as some on this dais have shared, the incommunicable experience of war. I can think of no better way to set in place what we should be about than having Mr. Lincoln's words available to all of those who are coming to visit those veterans in their final resting place.

Mr. Chairman, I thank you for your courtesy.

[THE PREPARED STATEMENT OF ROBERT WILKIE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Secretary, for your testimony. I now recognize myself for 5 minutes for questions and I will begin, Mr. Secretary, with this topic of electronic health record modernization.

Very simply, is the new time line for the electronic health record modernization go-live July 2020?

Secretary WILKIE. Well, that certainly is a goal that I would like to achieve. You and I discussed on the phone the reasons that I delayed the training on the system. Two weeks ago was always the date that I had chosen to make sure we would be ready, I am confident that we will be. I am also confident that Seattle will be on line later in the year.

Dr. Stone is actually more on the ground on that than I am and I think he can fill in the blank on some of the issues that I have missed.

The CHAIRMAN. Well, just before Dr. Stone, are you saying it will or will not be July 2020?

Secretary WILKIE. Well, that is my goal.

The CHAIRMAN. It is your goal—

Secretary WILKIE. Yes.

The CHAIRMAN.—right.

Secretary WILKIE. Yes.

The CHAIRMAN. Are you reasonably—do you think it is possible?

Secretary WILKIE. I am confident that we can fulfill our mandate.

The CHAIRMAN. The go-live will be July 2020, we are on track for that?

Secretary WILKIE. Well, I would hope that it would be earlier, but I am focused on making sure—

The CHAIRMAN. July—

Secretary WILKIE.—we are on a glide path to get there.

The CHAIRMAN. July 2020, if not earlier, we are on a glide path. I mean, look, we have always said on this committee that—and I think, you know, Ms. Lee has also said, we would rather get it right, but we also just want you all to be transparent with us and just tell us, you know, what you need.

Secretary WILKIE. I would also say, as a way of complimenting, this committee has done things that I have not experienced in my other positions in the Department of Defense with other committees. You have graciously recognized the complexity of this program. It is the most complex program the Federal Government has undertaken and you have given me gracious opportunities and great leeway to fulfill your mandate.

The CHAIRMAN. Well, look, I think—I hear what you are saying, that we are on track to go live by July 2020, it could happen earlier. I certainly hope that you will tell us if there will be more significant—

Secretary WILKIE. Yes, sir.

The CHAIRMAN.—delays beyond that. Okay?

Secretary WILKIE. Yes, sir.

The CHAIRMAN. I do want to get on to some other questions, though. Is the rationale for the delay development?

Secretary WILKIE. The rationale was that, when I reviewed it, the two portions of the program that were not ready for our clinicians were programs that are incredibly important, particularly to the west, travel and community care, those programs were not ready. We have a great relationship with our private sector partner, we have a great relationship with the Department of Defense, but I was not satisfied, and I promised you and Dr. Roe that, if I was not satisfied, we would not launch. We are working on those interfaces right now.

One of the highlights of our effort is that—and I should invite you to come see it—we have created the equivalent of what we in the Air Force call an air operations center that is working around the clock—

The CHAIRMAN. Well, we were told—

Secretary WILKIE.—to work this problem.

The CHAIRMAN.—we were told that before—we were told before it was changed management and workflow, and then a capabilities issue.

Dr. STONE. Mr. Chairman, if I may, it is development. There is about a thousand work processes that need to be written; those are substantially completed, but once you finish those work processes you have got to set that electronic medical record into a number of interfaces that plug into the rest of the system. There are 73 interfaces, 19 are completed as of today, and that is why we are delayed. This is development.

The CHAIRMAN. Thank you, Dr. Stone.

I want to move on to COVID-19 preparedness, coronavirus, and the supplemental funding request that is now before the Congress. Does VA need supplemental appropriations to prepare for a major coronavirus outbreak, including procurement of additional protective equipment, training for VA employees and deployment of VA

employees as part of disaster emergency medical personnel system teams?

Secretary WILKIE. Not at this point, Mr. Chairman. As you know from earthquakes that have hit California, we are a foundational response for the United States health care system when it comes to emergencies like this. We train for them year-round, because when hurricanes hit, when earthquakes hit, we are the responding force. We are testing our processes as we speak, we are making sure our supply chain is full. Right now I do not see a need for us—

The CHAIRMAN. What about staffing and funding for the Office of Emergency Management?

Secretary WILKIE. We are set, right now we are set.

The CHAIRMAN. Dr. Stone, do you agree with that?

Dr. STONE. I do, I do. Now, if this develops into a pandemic in which portions of the American health care system, we are going to have a different discussion, but at this time as we take a look at the planning and what was outlined yesterday in the presser that was sent out, as well as a brief yesterday from the White House, we see ourselves as well prepared.

Secretary WILKIE. Let me get you a brief on our emergency preparedness.

The CHAIRMAN. Yes, I just want to make sure that—we have this opportunity in this supplemental to—I just want to make sure you all have thought this through on what you might need. I mean, we saw what happened when just one person in Houston that they thought might have it, but I do not think that he did have it, but the reaction throughout that area.

I have gone over time. I want to recognize Dr. Roe for his 5 minutes.

Mr. ROE. Thank you. Just, Mr. Chairman, to dovetail in what you are talking about, you are absolutely right. I have noticed this for years in practicing medicine, what scared patients is the unknown. What you have to do, we have to get accurate information to people about this particular virus and what it does and what it can do. I think, if it is a 24-hour news cycle, you can get people completely worked up about this.

We have the resources in this country, as opposed to many countries. Dr. Stone may want to share his experience with someone in France to show you how different it will be here about how we handle these. We are the best in the world at this and we will get through this just fine, I feel very confident that we can.

I also feel, Mr. Chairman, that we in the Congress, whatever the number is, we are arguing about a number, we will provide the resources to take care of the American people. I have no doubt about that, that is not going to be an argument. When we figure out what that is, and we have to rely on the people who do this, we will provide those resources.

I want to ask a couple of questions. One, Dr. Lawrence, I want to start with you, because the thing that we hear in our offices back home more is how long—why is it taking so long to get my disability claim adjudicated, would you please just give us a run-down on where that is right now after Mr. Bost passed, I guess now, Mike, it has been 3 years ago that that bill passed.

Mr. LAWRENCE. Sure. As you recall and you alluded to, in 2013, the backlog of claims peaked at 611,000. Those were claims over 125 days and they were taking 6 or more months to process. Right now, the backlog this morning is a little north of 72,000; in November, it hit an all-time low of 64,000. We processed claims last quarter, the period of October 1st through December 31st, in an average of 91 days. There are some that are more complicated that take longer, no claim, no two claims are exactly the same, but this is a significant reduction. Compared to the same quarter at the beginning of Fiscal Year 2019, we processed 12 percent more claims with the same people.

We are providing faster service for veterans and more consistent results, so we are doing more with the resources you have provided us.

Mr. ROE. Well, thank you for that. I know that I have heard constituent after constituent talk about—and especially with the rapid appeals modernization went on—about claims that had been out for years that got adjudicated in 2 or 3 or 4 months, and these veterans are very appreciative.

Another thing very quickly I want to go to I think is one of the most—a very important component of the MISSION Act, which is the AIR Act. I would like to know exactly the status of the market assessments right now and that will form the basis of the recommendations to the AIR commission.

Secretary WILKIE. Yes, sir. We have conducted market assessments in six or seven Veterans Integrated Services Networks (VISNs), that is a component of the 96 market assessments that we are doing that look at our services, our footprint, our partnerships, everything from building new facilities to leasing other facilities. I have a report date of January 2022 to the Congress. I will continue to ensure that we do this as rapidly as possible so I can actually get ahead of that report date. I think it is absolutely vital.

We have never really had a complete inventory of what VA has and where VA is, and I do think that this is a key component for our future; without it, we will again be moving into the future blind, and I am very supportive of that part of the MISSION Act.

Mr. ROE. I hope that the Congress has the courage to carry out what—because it is critical for the future. We can not keep just throwing money at a problem, there is a more efficient way to do it, and it is just the way health care is provided today.

This was in yesterday's Washington Times, which I thought was very concerning, temporary doctors fill increasing shortages at health care facilities. We have a very good synopsis of what I have been saying now for years, that we have a shortage and in the next 10 years we are going to have to learn to do things more efficiently and better, both in the private sector and in the VA sector. I think this is one of the reasons that the AIR Act is so important to use the—and the MISSION Act, to use the best assets of both the private sector and the VA sector. I think as a shared responsibility we can take the best care of our veterans in that way.

My time has expired. I yield back.

The CHAIRMAN. Thank you, Dr. Roe.

Ms. Brownley, you are recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. Good morning, Mr. Secretary. I am going to try really hard to get three questions in, so we will see how I do.

The first question is around women veterans. I think you recently referenced that there are 780,000 women veterans in the VA; however, the budget represents—or references 545,000, roughly, unique women veterans. Can you confirm that the distinction is between enrolled women and actual veteran patients?

Secretary WILKIE. Right, there is a difference between enrollees and patients, and that is the same for men as well.

Ms. BROWNLEY. Okay. In some other testimony the VA said that in Fiscal Year 2019 the number of unique women veterans grew to 821,000. It just seems to me that the population—I am a little confused, but that population is not totally represented in the budget?

Dr. STONE. Congresswoman, there are 780,000 enrolled women veterans, 510,000 active users, growing to 548,000 active users in the 2021 budget. About 8 percent growth, about 9 percent increase in the budget.

Ms. BROWNLEY. Okay. We also know that women veterans represent the fastest growing sub-population of veterans and, you know, we are continuing to try to keep pace with that. Since Fiscal Year 2000 women veterans have more than tripled and are currently 30 percent of net new users of VA health care are female, yet the budget is only reflecting only about a 9 percent increase in Fiscal Year 2020. Do you think there is adequate sums of money here to meet the need?

Secretary WILKIE. That is for gender-specific care. We have a much larger budget for medical treatment that both men and women would need, because the conditions cut across gender lines.

Ms. BROWNLEY. Well, again, my data tells me that there is about 76 percent of women veterans now are assigned to a trained women's health primary care provider, which is still under where we aspire too.

Secretary WILKIE. Well, right now we have at least two dedicated women's health care providers in all of our VA facilities. We have hired just I think in the last year 7,000 providers and nurses, we have trained them just on women-specific issues. It is something that is absolutely vital if we are going to provide those questions.

Ms. BROWNLEY. Thank you, sir. Now I want to go to the caregiver program and I think you mentioned that the regulations will be published next week. I am going to take your word for that, the buck stops with you, Mr. Secretary. Assuming we will be reviewing those next week, where are we with regards to the new IT system for processing caregiver program applications?

Dr. STONE. The program is progressing well. The IT system has come online and we have moved most of the existing 20,000 families that are on this system. The second phase that will be exercised next month is the ability to pay claims or to pay the benefit on an automated basis instead of handwriting that number of checks each month. Then the third piece will be the automated intake of new applicants.

We are quite optimistic that by this summer the program will be ready for the Secretary to certify for expansion.

Ms. BROWNLEY. You are saying the summer of 2020 you will be able to accept applications electronically?

Dr. STONE. That is exactly where we would like to be. Please remember, this is a very complex regulation of more than 200 pages of regulation, and we do anticipate a robust response to the proposed regulation.

Ms. BROWNLEY. Can I just get your commitment then, if we fall off of that mark that you will let us know, so that we can stay abreast of that, I would appreciate it.

The last question is the issue around sexual harassment within VA facilities. Just in reviewing the budget, I know, Mr. Secretary, you have initiated a program, Stand Up to Stop Harassment, and just looking at the budget I can not really identify resources dedicated to that program and I am just curious if you could further articulate a little bit more with regards to funding, including advertising materials and videos, so that we are really getting this information out at every corner of VA facilities.

Dr. STONE. We have instituted a program called Stand Up to Stop Harassment. We have instituted about a half million dollars—or we put about a half million dollars into the budget to generate products that will train not only our employees, but also our volunteers and those coming through. You will also see in our lobbies pictures up about demonstrating respect for fellow veterans. All of those are present within the budget.

Secretary WILKIE. I would add to that, we are engaging in a new bystander training program. It is one thing to put up a poster, but we need those people who are in that facility to be trained. About 7, 8 months ago, I put in place a similar program that I put in place at the Department of Defense and that is a task force that looks at culture, it looks at the way we report these things. Dr. Stone has brought into his immediate office a senior-level official who focuses on nothing but that. That is part of this great cultural change that the active duty and the veterans component has to go through it.

Ms. BROWNLEY. Well, I thank you for that and obviously we are looking for persistence in this endeavor.

I am way over my time and I yield back.

The CHAIRMAN. Thank you, Ms. Brownley.

Mr. Bilirakis, you are recognized for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it. Mr. Secretary, thank you for your service and you truly are making a difference. I see it locally in the Tampa Bay area, but nationwide—

Secretary WILKIE. Thank you, sir.

Mr. BILIRAKIS.—and I appreciate your service.

The first question is, there have been some—Mr. Secretary, there have been some who have said the President's budget request is cutting services to homeless veterans by not requesting additional HUD-VASH vouchers. Is it true that there are over 10,000 HUD-VASH vouchers or 10 percent of all the HUD-VASH vouchers that Congress funded last year that are not being used?

Secretary WILKIE. That is true. Most of them are unused because they are in very high-cost areas that we have not been able to meet the rents. I have been in contact with—and I think I have men-

tioned this to the chairman—leadership particularly in Los Angeles. We are working with them to find some way to get around this problem, more transitional homes for veterans homelessness. We are expanding the facilities that we have, particularly in Southern California. Yes, that is true, we have 10,000 that have not been used.

Mr. BILIRAKIS. Yes, and we did have a hearing in Southern California with Congressman Levin and that is what we heard as well, and I think even in my area the cost of living is very high. I would appreciate you working on that and thank you for doing that. It is unfair, would you agree, that the Administration is being criticized for not requesting new vouchers when there are more than 10,000 vouchers available?

Dr. STONE. Sir, I understand your point. As part of this budget, we have added \$30 million for additional caseworkers to work those. It is specifically our problem is in very high-cost communities where we just can not get the participation of enough private owners to participate in this, but we are adding additional resources just because of the complexity of having to work each case.

Secretary WILKIE. I would add the success story—and Dr. Roe mentioned the decrease from hundreds of thousands to the 38,000—just in the last 2 fiscal years we have managed to find homes for 125,000 veterans and their families. The way this will continue to work, though, is that we have to enhance our partnerships with the private sector, with charities, with non-governmental organizations, so they can help us go where we do not go to find those veterans who are on the street.

Mr. BILIRAKIS. Getting the additional case managers will help you do that; correct?

Secretary WILKIE. Yes.

Mr. BILIRAKIS. It is a smart move. I mean, this is a priority of this Administration, obviously it is a priority of this committee as well.

Okay. Mr. Secretary, I have seen in The American Legion's testimony, which we will hear on a second panel, that VA should consider public-private partnerships with community hospitals to increase VA's market penetration in under-served areas by renting space in existing facilities. Now, we do not need that in my area, but in other parts of the country I think it is necessary. I also strongly believe that we can leverage the already existing framework of community health centers to increase VA's footprint.

Would you support these concepts and—well, just give me your opinion on that, because I think it is important, particularly with the community out centers. That is all over the country, they do such a wonderful job, and it would make a veteran's life a lot easier to travel there as opposed to going to a hospital, which may be hundreds of miles away. Yes, please.

Secretary WILKIE. That is the beauty of MISSION. In fact, I never remember the entire acronym, but the part, the words, the letters that I do remember are integrated network. MISSION allows the veterans the choice to find those community providers. There are about 880,000 community providers across the country that could be community hospitals or doctors or nurse practitioners.

Our goal is to get veterans to the care that is most advantageous to them.

Mr. BILIRAKIS. Thank you very much. Doctor, do you want to add something?

Dr. STONE. No, not in addition to what the Secretary said.

Mr. BILIRAKIS. Okay. Thank you very much and, again, thank you for your service. I am telling you, I hear it from veterans everywhere that you are truly making a difference. God bless you.

Thank you and I yield back, Mr. Chair.

The CHAIRMAN. Thank you, Mr. Bilirakis.

Mr. Lamb, you are recognized for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman. Mr. Secretary, everybody, thank you for joining us today.

Mr. Secretary, thank you for everything you are doing, but especially for starting off today by mentioning your father and his service in Vietnam and what he went through, because I really just want to focus for a second on the men and women who are out there right now with hypothyroidism, hypertension, Parkinson's symptoms, and bladder cancer, those four conditions that have still not been added to the presumptive list. I will just State up front that this is an injustice, it is an insult to these men and women.

I believe that the responsibility lies at Office of Management and Budget (OMB), I do not believe it lies with the four of you. From what I can see as publicly available, the Secretary wanted to add it back in 2017, then-Secretary Shulkin, OMB turned him down pretty clearly; the reasons are not clear, but they have turned him down. I just want to confirm your understanding of a few facts, though.

Do I have it right that, if you take these four conditions as a whole, there are probably around 190,000 veterans who would receive benefits under those four conditions and then that number would grow over time?

Secretary WILKIE. I think it would as to the growth. I would have to look at the actuary tables, because the population is——

Mr. LAMB. Right.

Secretary WILKIE.—beginning to leave us.

Mr. LAMB. 190,000 veterans who, as you say, are beginning to leave us, suffering from these incredibly serious conditions. I mean, just Parkinson's alone, the drugs can cost thousands and thousands of dollars for people every single year. The estimate I have seen publicly reported is that adding these four conditions would cost about 11 to \$15 billion over time; does that sound familiar?

Mr. RYCHALSKI. Eleven to 15 billion over 5 years?

Mr. LAMB. Eleven to 15 billion over 5 years.

Mr. RYCHALSKI. Correct.

Mr. LAMB. That is correct, Okay. That is what OMB has rejected due to the cost; is that correct?

Secretary WILKIE. I can not tell you what their reasoning is today.

Mr. LAMB. It is a fact that OMB has rejected it?

Secretary WILKIE. That has been replaced with a recommendation.

Mr. LAMB. The thing is that, I mean, I think that their case has been couched in terms of protecting the taxpayers, making sure we

can actually pay for the things we promise veterans, which all sounds nice in the abstract, but the exact same OMB is promoting and requesting a budget that asks for \$22 billion of an increase this year alone as VA as a whole. It is not as if they are pinching pennies throughout the VA, it is not as if they are pinching pennies throughout the government, we now have over a trillion dollars of budget deficit. This is about choices. If these four conditions going on the presumptive list would mean 11 to \$15 billion over 5 years, that is in fact less than VA's overall budget request increase this year alone; correct?

Secretary WILKIE. That is—

Mr. LAMB. Just the math, it is a mathematical question.

Secretary WILKIE.—yes, the math is correct. The distribution probably would not work dollar-for-dollar, given other needs that we would have.

Mr. LAMB. Yes, and no one is saying that there are not other needs, but this is about making choices. You know, when we passed the expansion of community care, the MISSION Act, one of the things that we called attention to was the conflict between mandatory and discretionary spending that that would create, and we were very concerned about it. As you noted, people were concerned about privatization of the VA.

I will commend you for how you have executed MISSION Act so far. This year went smoothly in my district, from what I can see, and the Administration has continued to request more money to fund MISSION Act so that that did not happen, but, again, it was about choices. The Administration's response at that time was, basically, do not worry, we are going to make sure veterans get the money that they deserve; we are going to take care of these people if we send them out into the community, we are going to pay, we are going to find a way. That is now not happening with the people who are suffering from these four conditions. As you said, they are starting to leave us. The clock is ticking for them, the clock is not ticking as much for a 35-year-old who might want to get medical care in the community, but that is who OMB and the Administration is choosing and that is what is wrong. I know you are working hard for these veterans and you are making the case, I can tell.

Please, do not give up and try to convince these people over there that this is not about saving money. Our government sprayed them with Agent Orange, we are the ones that did it to them.

Dr. STONE. Congressman, none of the decisions that we have recommended to the Secretary or have been recommended to OMB have been based on how much this costs.

Mr. LAMB. Thank you.

Dr. STONE. It has to do with the science and the science, unfortunately, is difficult. The National Academy of Science went over these four conditions and—

Mr. LAMB. It is.

Dr. STONE.—unfortunately, they—

Mr. LAMB. My time is about—it is impolite to cut you off, my time is about to expire, but I just want to reiterate that the level of evidence related to these four conditions is similar to the conditions that are already on the presumptive list, they are not novel or unique in that respect. Science can differ, but you also have to

add into it that it is similar to how we have done it in the past and, again, the clock is ticking. At a certain extent it becomes who bears the burden, the government or the veteran, and I believe it should be the government.

Mr. Chairman, I yield back.

Secretary WILKIE. I know you are over your time, sir, but I will give you my commitment, because it is personal, that the Vietnam soldiers have particular meaning to me. That was the world I was born into and I take your passion seriously.

The CHAIRMAN. Thank you, Mr. Lamb. Mr. Secretary, I appreciate your responses to Mr. Lamb on this issue. I agree with him that I think—I do not see you gentlemen responsible for these four conditions not being listed on the presumptive list. This is something I hope that we can resolve quickly.

I now recognize Mr. Bost for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman. I want to thank you all for being here as well and what all you are doing.

Dr. Lawrence, as you know, the VA recently faced challenges responding to legislative requirements like those under the Forever GI Bill that Congress passed to enhance education benefits for our veterans, servicemembers, families, and survivors. How would you assess the Veterans Benefits Administration's (VBA's) state of preparedness today, particularly from an informational technology perspective, and if you would require—if you were required to carry out implementation of additional legislative provisions, what challenges would you still face?

Mr. LAWRENCE. As you know, part of what got us through the journey through the GI Bill in calendar year 2019 was the old technology and the inability to respond agile to the new requirements passed in the Forever GI Bill. The assessment coming out of that, which was completed successfully on December 1st and we are in the process of truing up per the Secretary's guidance, is that the technology is very, very old, making it very difficult for us to provide veterans world-class service that they are used to with the private sector, as well as limiting the possibilities that additional changes to the GI Bill will be done cheaply, if at all.

There is a real sense the time is near to not just continue to upgrade this old technology, but to really rethink the acquisition of new commercial off-the-shelf software and implement it in such a way that going forward we will not face the same problems.

Mr. BOST. If you were provided with additional funding for IT, what would your priorities be?

Mr. LAWRENCE. Sure. We have done a preliminary assessment, but I will give you a broad assessment. We would purchase three commercial off-the-shelf packages, one called Customer Relationship Management, so when veterans call up we know everything about them when we are on the phone. This happens when you interact with a bank or insurance company now. We will purchase high-tech computing power to do calculations. This happens when you take a dependent off your insurance company and they tell you the reduction or the addition. We will have sufficient data capacity, so we can have all the information from the schools and the veterans, so that it is all right there.

These are commercial off-the-shelf acquisitions, companies that exist that do this all the time now. With additional funding, that is what we would do. The implementation of this should take between 18 to 24 months. We have MITRE presently studying this exactly as to how it would be done, so that we could do this when the resources are available.

Mr. BOST. That is what I wanted to get on the record, so we knew, you know, the efficiencies we can move forward with the proper investments.

My next question is for Dr. Stone. You have spoken about S. 3084, that is a bill that passed out of the Senate in January that would correct a technical error in the law that impacts leaders working in senior executive positions throughout the VA and within the VA health care system, and it is actively making it harder for VA to recruit and retain the necessary talent to serve veterans. I have been working to get the bill passed out of the House as soon as possible. Could you please briefly summarize what the advantage of having this passed would do for you?

Dr. STONE. Congressman, 10 years ago there was an error made in two sections of the law that allowed us to pay Senior Executive Service (SES) equivalents a market rate. We discovered this as part of the last pay raise, it placed us in a very difficult position. That in essence states in one section of the law we may have overpaid those senior leaders. I have 30 active senior leaders, these are the people that had my pharmacy program, had our suicide prevention program, these are the key working leaders of this organization.

The problem we have got as this sits is that I can not do anything with those employees. We will trigger additional potential debt for them unless we lower their salaries. In addition, we can not promote any of them, we can not move them someplace else; I can not hire, they can not retire. This is an extraordinary morale killer for 30 of our key leaders and we would hope that your efforts would result in continued movement.

Secretary WILKIE. I would add to that, and the chairman and Dr. Roe have worked on this in the past, we have a larger issue and that is remaining competitive when it comes to paying doctors and nurses, particularly in high-end specialties. It is my desire to break out of the compartments that have existed in terms of the Federal pay scale for well over 100 years. This committee has given us authorities for loan forgiveness, it has given us authority for moving expenses, it has given us some authorities to raise salaries beyond what they would normally be, but that is an issue that is going to reach a point that we will have to come back and have a much longer discussion.

Mr. BOST. Thank you, Mr. Secretary.

My time has expired and, with that, I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Bost.

Mr. Levin, you are recognized for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman. Mr. Secretary, to you and your team, I thank you for being here with us and on behalf of my communities in San Diego and Orange County we thank you for your service to our veterans.

I wanted to follow up as chair of the Economic Opportunity Subcommittee on one topic that my friend, the ranking member, Mr. Bilirakis brought up and that is the HUD-VASH program. Specifically, we have heard testimony in our recent subcommittee hearings on the difficulty in hiring and retaining case managers that are critical to operating the program. Studies have shown how effective HUD-VASH is at reducing veteran homelessness, but obviously without sufficient case managers veterans can not access the vouchers and that is certainly true, as was indicated before.

What is the VA doing to address the case management staffing issue? I heard the 30 million that you brought up before, but understanding the key challenges, recruitment and retention, and offering a competitive salary for these case managers. Do we need to adjust the pay scale for HUD-VASH case managers and, if so, what would that require?

Dr. STONE. I think we have got room to move higher. Our problem primarily is in high-cost areas, as I mentioned before. It is not just the cost of housing, it is the cost of living for that employee to stay in. We could use relief in our Title 38 authority for those social workers.

One of the success stories that we have had in Los Angeles is to make that HUD-VASH voucher social worker part of an overarching team integrated with the rest of the medical care team. Much of the issues of our persist homeless veteran really relate to chronic, severe mental illness, as well as drug abuse, and the full integration of those programs has resulted in much higher job satisfaction. Although one of the frustrations is, we can bring people into long-term domiciliary care, but after 6 months or so when we have got people drug-free and under good control transitioning out is very frustrating into the community, especially in high-cost markets like you represent.

Mr. LEVIN. Thank you for that. We look forward to working with you in a bipartisan way on trying to figure this out, whether it be the fair market calculation, ensuring that the voucher is commensurate with the actual cost of living in a particular area, or the eligibility criteria, we have legislation to expand that, and then the case managers, making sure that their salaries are competitive. Let us know how we can work with you.

The other thing that we have done this year is we have made several visits to Muskogee, Oklahoma—and it is good to see you again, Dr. Lawrence—for the GI Bill call center regional processing office. We repeatedly heard the need for funding and you went into that a little bit, but I was amazed that one such system is now over 50 years old, it is still in operation, and it seems to me that the budget request does not reflect everything that you need and instead we seem to be left in this cycle of band-aids and IOUs for a system that is desperately in need of a revamp.

Mr. Secretary, obviously, I hope you would consider education services IT a priority and, if so, how can we better reflect that priority given that VA, as my friend Mr. Lamb said, had their own budget increased, one of only two Federal agencies? How can we better reconcile the needs for the GI Bill IT infrastructure?

Secretary WILKIE. It is actually an issue beyond just the GI Bill and is one that Ms. Lee has been very involved in, and that is a

look at our entire IT infrastructure readiness. I will admit that VA has been underfunded on the IT front throughout the last several decades, we were right at the bottom. That is a bipartisan criticism, both Republic and Democrat administrations. Raising that IT infrastructure profile is absolutely the key. Moving things to the cloud, getting people away from actually having to touch a claim, that is what we are working on. Dr. Lawrence, as you said, has done an incredible job at Muskogee, but we have a much larger issue than just the GI Bill and we are working to correct that.

Mr. LEVIN. Thank you for that, Mr. Secretary. Again, thank you to the whole team. I do hope, while this is an election year, things get a little crazy, that we are able to find those areas of common ground where we can work together in service of our veterans. I know that Mr. Bilirakis and I share that ideal in our subcommittee and we look forward to addressing these and related issues.

Thank you, again, and I will yield back to the chairman.

Secretary WILKIE. Thank you, sir.

The CHAIRMAN. Mr. Bergman—thank you, Mr. Levin—Mr. Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. Thanks to everybody for being here.

You know, we all sometimes hear the term we are not in a sprint, we are in a marathon. I would suggest to you this is not a marathon, this not even an ultra marathon. More appropriately, I could maybe categorize this as a never-ending, multi-generational relay race in which the baton is passed from generation to generation, whether that generation be human or technology, because as we hear what all of you have done on the technology side is we advance everything from the Electronic Medical Record (EMR) to other digital technologies as we do our business processes, but also the generation of veterans, whether they be World War II, Korea, Vietnam, Desert Shield, Desert Storm, Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and going forward. Thank you for all the effort, both here on the committee side, but also on your side, to understand what is the baton we are actually passing, because in some cases it is going to be technology, but we can never forget the human side of that.

Mr. Secretary, I have got a couple of rapid-fire, yes-or-no kind of things here, so these would be—okay. When this request was released earlier this month, Chairman Takano alleged that, despite significant increases in VA funding overall and for mental health care, and suicide prevention in particular, this budget would, quote, “direct resources outside VA into grant programs and the PREVENTS Task Force instead of being used to explicitly support veterans in crisis at VA.” Is that assertion true?

Secretary WILKIE. I do not agree with it, no, sir.

Mr. BERGMAN. Okay. Is it true that most of VA’s suicide prevention resources and efforts support suicidal or at-risk veterans inside the VA health care system?

Secretary WILKIE. Yes, sir. If I can go beyond the yes or no, the reason that is because, something that the chairman has identified, 60 percent of those who take their lives we do not see. Yes, the majority of the funds are going internally because we are not touching those folks out there.

Mr. BERGMAN. Right. Then is it true, despite tremendous growth in mental health and suicide prevention funding, staffing, and programs within VA medical facilities, that 20 servicemembers and veterans die by suicide every day and that 14 of those, as you just articulated, had not sought VA care in the 2 years prior to their death?

Secretary WILKIE. That is correct.

Mr. BERGMAN. Okay. Is it true, based on VA's experience with Choice and now with the MISSION Act, that expanding access in the community leads to increased reliance on VA care, not reduced utilization or capacity?

Secretary WILKIE. I agree with you, yes, sir.

Mr. BERGMAN. Okay. Now, you have equated the success VA has had with respect to reducing the number of veterans who are homeless with the success VA hopes to have with respect to reducing the number of veterans who die by suicide to increase the success through the Improve Act.

Secretary WILKIE. Yes, sir.

Mr. BERGMAN. Could you please respond to those who argue that these two crises are, I will call them, mutually exclusive? Homelessness and suicide are so different that the same approach could not and will not be effective in both cases?

Secretary WILKIE. They are part of the same continuum. The solutions for homelessness where we have reduced to 38,000 have involved us getting into the community with partners to find those people who are homeless, those veterans that we do not see and we do not have the resources to go out and touch, that is the formula we need for suicide, in my opinion.

I will give you an example, the State of Alaska, the most veterans per capita in any State, more than half have no contact with us. I have to go to the Federation of Natives in Alaska and ask them right now, without me giving them any financial support, to go out and please help us find those veterans we do not see in the wilderness.

Mr. BERGMAN. Okay, thank you.

Dr. Stone, just one quick one here. VHA has requested \$270 million for the Office of Rural Health, ORH. ORH is authorized to develop and implement innovative and successful programs to improve care and services for veterans who reside in rural areas of the United States. How is ORH using its ability to innovate on behalf of our rural and remote veterans who might benefit from next-generation programs, are we utilizing any new technologies?

Dr. STONE. Yes. This office has been one of the most creative and innovative offices within VHA as we seek to reach the remote and isolated veteran, whether it is helping us in partnerships with companies like Walmart or helping us with our Phillips partnership where we are placing self-contained units that allow us to do remote visits in VSOs around the Nation, this office has allowed us to really fund creative and innovative ideas and really bring in partnerships like the major carriers that have helped us with the contact with veterans without costing text lines and cost against the veteran.

Mr. BERGMAN. Thank you. I see I am over my time. I guess, as I listen to you talk and starting with the analogy of the baton, I

guess each time we pass that baton, if we are doing it right, it is going to be a better baton, a more capable baton that we pass along to better serve our veterans.

Thank you, Mr. Chairman, and I yield back.

The CHAIRMAN. Thank you, General Bergman.

Mr. Brindisi, you are recognized for 5 minutes.

Mr. BRINDISI. Thank you, Chairman and Ranking Member, and thank you all on the panel for your service to our Nation's veterans.

First off, I do want to add my voice to those who are calling for the VA to add additional diseases for the presumptive list for service connection based on Agent Orange exposure. Secretary Wilkie, I wanted to ask you a question, because last week the Under Secretary for Memorial Affairs, Randy Reeves, came to my district at my invitation to discuss the creation of a State veterans cemetery in New York. As you know, New York is one of the few states left that does not have a State veterans cemetery, so I appreciate him coming. The district I represent in particular has about 56,000 veterans right now who are underserved by a State veterans cemetery or access to any veterans cemetery, national or State. We had a good meeting and at that time Under Secretary Reeves informed us that expansion projects are a top priority for them and then National Cemetery Administration (NCA) works through new construction grants which meet the statutory requirements.

I just want to ask, is your budget request enough to meet the needs of all top-priority sites, both expansions and new constructions?

Secretary WILKIE. For the top-priority sites that we have, and some of those are in New York, some are as far away as Utah and Wyoming, yes. I actually had this discussion with Leader Schumer about the concept of the cemetery in your district. We are going to make sure that the State of New York has every access to the grants that we give to help states on that. You are right, that many veterans, it is a gaping hole in service.

Mr. BRINDISI. Thank you. I want to put a plug in for Under Secretary Reeves, he really has done a great job and I can think of no person I would rather see overseeing that program rather than him. He was fantastic when he came up to the district. So thank you for having him come up.

I also want to ask, Secretary, about State veteran home construction grants. Your proposed budget includes level funding for State veteran home construction grants and we have one such home in my district in Oxford New York. I understand there has been a backlog of State grant requests and Congress appropriated additional funds to address this backlog in fiscal years 2018 and 2019. Can you tell us what this backlog looks like now and how many of these grant requests already have State matching funds lined up?

Secretary WILKIE. I will have to get back with you on that—oh, no—Jon?

Mr. RYCHALSKI. I think in 2018 we received a plus-up that pretty much brought the new construction backlog down to about 70 million. We do have in service a static request now. Most of the—so I think the backlog has gone up from about 90 million to about

right around 300 million, but most of that is for renovation, not for new construction. I think we eliminated most of the construction with the plus-up, so that is sort of where we are today.

Mr. BRINDISI. Okay.

Dr. STONE. If I could add, sir, we have 154 State veterans homes that we are in partnership with. The Association of State Directors was in town here this week, we have been talking to them and discussing what the future is. We know that over age 75 there are 2 million veterans today, that will grow in the next decade to 3 million. We need the 20,000 beds that are in the State homes, we need to expand that. We have in our chronic living facilities about 45,000 beds, we need much more than that. What you will see from us over the next 6 to 12 months is the development of an elder care strategic plan and a cognitive decline strategic plan that really begins to garner how to approach this.

This also ties in to the rollout of the caregiver program, because most of those veterans would rather stay at home if they possibly could and it is why all of this fits together.

Mr. BRINDISI. Are you studying where across the country that the needs are right now?

Dr. STONE. Yes, we are. As part of the AIR Commission, we have taken a look at where the demand is. One of the things we recognize, in spite of the very significant decline in veterans in the Northeast and the Northwest, those that are staying are substantially challenged and are engaging with us at remarkable rates.

Mr. BRINDISI. Is that something, when you have the conclusions of those results, can you share that with us?

Dr. STONE. They will come here, yes.

Mr. BRINDISI. Okay, all right. Then just finally, Dr. Stone, again, thank you for coming up to the district to visit the clinic in Bainbridge, New York. I appreciate your concern with service to rural veterans. I just want to talk just generally about the budget and do you think there is enough in there to address the needs of veterans who are living in rural areas? What more can we be doing?

Dr. STONE. I think there is enough in here and we are comfortable with the budget. The movement of veterans has got to be tackled in the AIR Commission. You and I have had this discussion as we wandered around that great town of Bainbridge and met its citizen, and I appreciate the time you have spent and your passion for this. How we approach the future lay-down of this system is going to require a recognition of the evolution of how we deliver health care in America. You know, we have grown to 2.6 million telephonic or face-to-face video visits last year, about 20 percent of our veterans will be working off of video visits and they have some of the highest satisfaction rates of any of our visits.

I appreciate the ongoing dialog that you and I are having on this. I am not sure we are going to come to complete agreement, but we both want the same thing and that is the care of the American veteran.

Secretary WILKIE. I would give one more statistic. In Fiscal Year 2019, more than 900,000 veterans had at least one episode of telehealth care, I hope that is bigger, that grows. I will tell you, my focus has been on rural and Native populations, they serve in numbers greater than any other communities in the country.

Mr. BRINDISI. Thank you all very much.

The CHAIRMAN. Thank you, Mr. Brindisi.

Mr. Roy, you are recognized for 5 minutes, but if you need to get settled, I can call on someone else.

Mr. ROY. I will go ahead and defer to someone, if you do not mind, one round.

The CHAIRMAN. I will call Mr. Banks.

Mr. ROY. Thank you, Mr. Chairman.

Mr. BANKS. Thank you, Mr. Chairman.

Mr. Secretary, I was encouraged to see the President's budget proposal for the Office of Information and Technology reflect the conversations that we have been having, both on the committee and in the VA, about the importance of IT as the platform for more responsive, high-quality services for veterans. The \$540 million increase, which works out to about 12 percent, is absolutely warranted.

What will this funding level enable you to do in terms of particular IT systems and the veteran-facing programs that they support?

Secretary WILKIE. It will allow us to focus and, in addition to the infrastructure readiness program, it actually—it gives us a map as to where we need to be. It focuses on infrastructure, on cloud migration, decommissioning legacy systems, which you have heard some of my colleagues talk about. I think the most important thing—and Ms. Lee and I have had a conversation about this as well—is recruiting the cyber workforce. I will admit that VA has been underfunded in IT, so the challenge is to catch up in those deficits, and that will impact caregiver and Colmery as well.

Mr. BANKS. Let me turn to Electronic Health Record (EHR) for a moment. I am interested in your thought process behind the new July 2020 date that you have already talked about a little bit for the initial go-live in Spokane. How do you plan to use these additional 4 months to improve the system, most importantly by pulling key capabilities forward into the initial capabilities set?

Dr. STONE. I think you have hit the two key points. There is a capability set, sir, that are in the capabilities, set 1, that has to be developed and delivered by the vendor, but should we use the couple of months extra to take pieces that are in capability, set 2, and draw them forward? Most importantly, online prescription refill. 11,000 times a month the Spokane market veterans refill online prescriptions. We were going to lose that capability in capability set 1, set up a call center, do it all manually to impact that, but as we take these couple of months extra the debate has been is the interface well enough developed for our computerized pharmacies to draw the capability forward, and that is a recommendation that we hope to be able to recommend to the Secretary in what we call capability set 1.1.

Mr. BANKS. Okay, that is helpful.

Mr. Secretary, I do have to say I am struggling a little bit with the size of the remained—with the requested EHR increase. It is a \$1.1 billion increase over this year and a \$400 million increase over the most recent Fiscal Year 2021 cost estimate that I have seen.

Let me say up front, I absolutely support the \$90 million increase to accelerate the implementation of the scheduling system, but I have a hard time seeing how VA could even spend an \$850 million increase for infrastructure upgrades. I wonder, Mr. Secretary, if you could unpack that for me a little bit?

Dr. STONE. If I may, sir, with permission of the Secretary. You see about \$685 million in the budget for infrastructure development. We are moving from ancient cabling in these old buildings to 5E or 6 cabling. This is the majority of the improvement in the cabling of the building. Second, the control of heating and cooling in our switching stations in old buildings is about a 2 and a half billion dollar cost over the next 3 years, and that is what you are seeing in much of that increase.

Secretary WILKIE. The greatest challenge, and Dr. Stone touched on it, is ancient buildings. I am spending millions and millions of dollars building closets right now to house equipment, because the facilities, some of which are 100 years old or older, cannot accept the kind of infrastructure that we need to get these programs online.

Mr. BANKS. Mr. Secretary, with the time that I have left, I want to emphasize the importance of accelerating the scheduling system, as I noted a moment ago. I was disappointed with the original 5-year schedule and the fact that your budget speeds it up to 4 years is definitely an improvement. Beyond words on a page, this means that VA medical centers in Indiana and Ohio are going to have a modernized appointment scheduling system in place next year. That is a big win and I very much appreciate that leadership.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Banks.

I now recognize Mr. Pappas for 5 minutes.

Mr. PAPPAS. Thank you very much, Mr. Chairman. Thank you to our panel for your commitment, your unwavering commitment to our veterans, I really appreciate it.

Mr. Secretary, I appreciated your comments about MISSION Act and I know in my district we are seeing already the ways in which MISSION is improving outcomes for our veterans and opening doors of care, quality care for veterans across our State. That of course only will continue to work if our provider networks are adequate and our networks will only be adequate if those providers are paid in a timely fashion. I am here to tell you that there is palpable frustration in the provider community in my own State. That has ebbed and flowed, frankly, over a number of years as we have seen different iterations of community care, so this is nothing new, but the hospital association in my State estimates \$134 million in outstanding claims unpaid for community care.

We had a hearing 2 weeks ago in the Oversight and Investigation Subcommittee and Dr. Matthews told us that there are more than two million aged claims in the VA system that she hopes to address by the end of this fiscal year. That is absolutely important, but in addition to that, we know that a number of the contractors with VA, these third party administrators, also have, you know, to be able to come to the table here to help solve this problem.

I am wondering if we have your commitment to address this, to deal with these legacy claims, to make sure that our providers are

paid in an appropriate and efficient manner, and that we can allow MISSION Act to flourish?

Secretary WILKIE. Absolutely. Without it, MISSION act does not work.

I can tell you that since MISSION came online we have adjudicated 11 million claims just from MISSION and disbursed about 3 and a half billion dollars, but the legacy and catching up with the legacy is absolutely vital or we will start seeing a reduction in that 880,000 number when it comes to partners that we have.

Dr. STONE. Sustainment of the delivery system and the contracts that we have with providers, we have taken a look at a number of rural areas. We have a higher penetration with our third party administrators of contracted providers than does Medicare in many of the markets, we can only sustain that if we pay people on time.

What Dr. Matthews related to you last week in testimony is exactly where we want to be. I can tell you that in this month alone we have reduced our backlog by 200,000 and so I am pleased at the direction that she is going. It is a promise we made to the Secretary to really correct this. It is one of the most frustrating areas for all of us, but part of this has to do with growth, part of this has to do with just getting rid of antiquated processes and moving to what needs to be done, and that is pay people in a timely manner.

Mr. PAPPAS. There are a number of issues certainly at work here, from authorizations to IT systems, and, you know, we can really get down in the weeds on this issue.

One of the things I wanted to find out from you today, if you feel that the budget is right-sized for community care and that we have adequate staffing within VA to be able to work with these providers on this issue.

Dr. STONE. We do feel that the burn rate of dollars in this year's budget, as well as future years' budget, are right; however, we have got a lot of new benefits and 3 months from now I may be up here giving you a different answer, but right now we look to be right on target of our burn rates for community care. Yes, we are staffed appropriately and have brought in adequate contractor support to support us with the processing of claims.

Mr. PAPPAS. My subcommittee has also done hearings on whistleblowers and the Office of Accountability and Whistleblower Protection (OAWP). I know there is a significant increase in this budget proposal for OAWP and I am wondering if you could talk about your commitment to seeing improvements in this office, ensuring that, you know, the voices of these whistleblowers will be protected, so that they can help improve outcomes for our veterans.

Secretary WILKIE. We are. There is a 26 and a half million dollar increase in the request for OAWP and that also means we are bringing in more investigators. They received about 2900 complaints last year and right now there are 167 investigations going on. That is absolutely key.

The addition to that is, I am not simply relying on OAWP for accountability. We have released over 8,000 people, people who were not fulfilling their mandate. We approach this from different angles as well.

Mr. PAPPAS. Great. Well, thank you for your commitment, your work, and I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Pappas.

Mr. ROY, you are recognized——

Mr. ROY. I thank the chairman——

The CHAIRMAN.—for 5 minutes.

Mr. ROY.—I thank the witnesses for being here today. Thank you, Mr. Secretary.

Yesterday, I had the privilege of going over to Administration for Strategic Preparedness and Response (ASPR) over at U.S. Department of Health and Human Services (HHS) to visit with them about what is going on with the coronavirus and it has been raised a couple times in here, but I am correct, right, that the VA has a presence over there as well in ensuring that we are doing what we need to do——

Secretary WILKIE. Yes.

Mr. ROY.—in coordination to deal with the coronavirus?

Secretary WILKIE. Yes, we do.

Mr. ROY. They are active part of that discussion and debate?

Secretary WILKIE. We are part of the task force.

Mr. ROY. That is good. Let me ask you a quick question, because I have got limited time. Are you familiar in general terms with the overall budget submitted by the President? I know, obviously, specific to VA, but in broad terms?

Secretary WILKIE. In broad terms, yes, sir.

Mr. ROY. Well, the reason I ask is because there were some charges made earlier about what is happening to the other parts of the budget and we are here, obviously, to talk about the VA budget, we want to make sure it is robust to accomplish the objectives. As I often say when I am in the district, I am proud to represent Fort Sam Houston, I represent Army Futures Command, about 80,000 odd veterans, and outside of Military City USA, San Antonio, and, you know, what I am talking about, I talk about that we want to make sure that our men and women in uniform have a clear mission, the tools to carry it out, and the care when they get home. We want to make sure that is done here and we are talking about the entirety of the budget.

Would you agree, at least based on your understanding of the budget, that what the President's budget submitted would balance in 15 years, within a 15-year window?

Secretary WILKIE. That is my understanding, yes, sir.

Mr. ROY. That in doing so it does assume certain growth rates, 3 percent growth rates and relatively low interest rates? In other words, it is still pretty aggressive. In order to balance in 15 years, you have to have a massive economic growth in order to achieve that objective. Is that a fair statement?

Secretary WILKIE. Yes, absolutely.

Mr. ROY. In other words, we have a massive problem to deal with right now. We are racking up \$110 million of debt an hour, we have got over a trillion dollars a year that we are piling on, and we have got \$23.4 trillion of debt. Do those numbers sound roughly correct?

Secretary WILKIE. Yes.

Mr. ROY. Are you aware of any budget being yet proposed by the House Democrat majority?

Secretary WILKIE. I have got to be honest, I have not followed that, no, sir.

Mr. ROY. Okay. Well, I will tell you, I have not seen one. I was just walking over to Oversight and ran into some of my—we could not go to a budget hearing this morning, we had Director Vought in a couple weeks ago, no one on the Budget Committee is talking about a budget being presented by House Democrats. I am rather intrigued by all the complaints about what is going on. When we talk about cuts in Medicare, I am looking at the numbers presented by the President's budget, \$722 billion for Medicare in 2021, going up to \$1.269 trillion in 2030, increasing every year in between. Social Security, \$1.1 trillion 2021, up to \$1.9 trillion in 2030, increasing every year. Medicaid, 448 to 607, increasing every year.

What we have are savings measures being put in place on the margins to not impact benefits that are, frankly, in line with proposals put forward by the OMB under President Obama. Does that sound right to you based on what you understand the President has put forward or can you comment?

Secretary WILKIE. I can not. I did not follow budgets in the last Administration.

Mr. ROY. Okay. Well, that is what my understanding is, having served on the Budget Committee and asking these questions of Members that have come before the committee, that these are the numbers. When I hear the-sky-is-falling rhetoric about what we are doing with respect to cuts in other areas, I want to be honest, okay, because there are not cuts going on to Medicare, Social Security, coming from the budget and the President. The budget put forward by the President, frankly, in my view, is not aggressive enough in what we need to do for the fiscal health of this country. We need to do a better job to figure out how to get the balance. Our kids and grandkids deserve better than \$23.4 trillion of debt and climbing.

I would put all of that in context to say that we are here with a robust budget for the VA, in the context of a budget that was proposed by the President that balances in 15 years. I would like to hear from my colleagues on the other side of the aisle something where we are working together to try to achieve that or improve upon it.

Let me ask—

Secretary WILKIE. I would—

Mr. ROY.—something—do you have a comment?

Secretary WILKIE. No, I would just say that this budget, I argue, reflects confidence in the direction that the VA is headed. We are in a position that this Department has not been in decades. Confidence, the satisfaction of those veterans who use us, modernization of all of our programs, so this is a validation of the good work that all of our people are doing.

Mr. ROY. Well, I appreciate that and I have got limited time left. Let me ask one last question. With respect to Choice and MISSION, I am a big proponent of what we are trying to do there in community care, you know, upwards of 33 million now served through those programs. It is great, I get a lot of positive feedback,

but the one problem we get whenever I talk to veterans is health records and the clunkiness of sort of moving in and out of the system and going to community care. What can you say about this budget and specifically—it is a pretty big jump in the technology dollars and so forth—what can you do to tell us that you are going to solve the problems that many of our veterans are facing using health records to move in and out of the system to use community care? Thank you.

Dr. STONE. We are on schedule, sir, and with the chairman's forbearance, I would say we are on schedule to roll out the health information exchange, which brings 225 vendors and systems of health services into an integrated, interoperable electronic records system within the next 6 to 8 weeks.

Secretary WILKIE. Interoperability is the key.

Mr. ROY. Thank you.

The CHAIRMAN. All right, thank you, Mr. Roy.

I now recognize Ms. Lee for 5 minutes.

Ms. LEE. Thank you, Mr. Chair. Thank you all for being here and, before I get into my questions, I just want to briefly talk about the postponement of the Electronic Health Record Modernization (EHRM) project and I think we have all had those discussions on how we anticipated that this was happening. I think from an oversight point of view you take a serious risk in terms of, you know, being okay with postponing. I just hope that we continue to have a transparent update, especially as the health information exchange goes live, I would like to have an update at that point, as well as on June 5th when you have your—

Secretary WILKIE. Yes, ma'am.

Ms. LEE.—mandate, your assessment date on that.

Then, finally, just highlighting that giving your practitioners the power to come to you and the freedom to be able to say we are not ready, also again understanding there is a certain balance as well of at some point you just have to sort of rip the band-aid off and move with what you have. Understanding that ultimately the veteran's care is important, making sure we are just in constant conversation about that, and understanding what is going on would be greatly appreciated.

I want to talk about the VA infrastructure modernization. It is a Department-wide investment, each administration and office in the VA has to play the same role in assessing the needs and whether some level of contribution is required. For instance, in the case of funding infrastructure for EHRM, the maintenance and regular refresh of that infrastructure and related physical infrastructure investments, Office of Electronic Health Record Modernization (OEHRM), Office of Information and Technology (OIT), and Veterans Health Administration (VHA) have a responsibility. However, there is little to no transparency in the budget that was submitted that clearly lays out how much of an investment is expected to be made and where the money is coming from and, without that transparency, there is no way to assess that the \$1.2 billion OEHRM investment in infrastructure is going to get us where we need to be.

The question is, at least in the case of EHRM, did OEHRM, VHA, and OIT sit down and hammer out the infrastructure invest-

ments, including refreshing that infrastructure during the implementation period, and nonrecurring maintenance, and come up with a number and a plan?

Mr. RYCHALSKI. Ma'am, I can answer that. The answer is, yes, they did. In fact, we made a transition from the infrastructure piece being partially funded by IT and partially funded for EHRM, putting it all in EHRM. They have teams doing infrastructure assessments and the modeling of the costs are based upon those models. We can actually walk the budget numbers much more granular to actually the specific sites.

Ms. LEE. Great. I would just like to see the number and the plan.

Mr. RYCHALSKI. Yes, ma'am.

Ms. LEE. I want to go on and talk about the budget includes the \$1.18 billion for infrastructure readiness for EHRM and additionally \$1.85 billion in nonrecurring maintenance. How much of that \$1.18 billion infrastructure improvement would be needed, is needed outside of EHRM to fully modernize VA's infrastructure? Just really put it more simply, if there was not the EHRM project, how much of this would be needed to bring the VA to an acceptable level of technology?

Mr. RYCHALSKI. I can answer that as well, and I would say all of it and that is infrastructure. I think as the Secretary mentioned, to upgrade communication closets and when you see some of them, you know, you would be truly shocked. In fact, there was one anecdote that after the upgrade, I think it was in Spokane, the infrastructure upgrade with the technology, they were able to change login times from something like 30 minutes to like 15 seconds. I mean, it is really—it is that significant.

Ms. LEE. Okay, great. Just one final thing. On the VA's Integrated IT and Operations-Electronic Health Record Modernization (ITOP-EHRM) alignment, the Department plans a full transition to eradicate the cumulative technical debt in 4 years, which I completely appreciate. Based on this alignment plan, a significant number of systems, especially the end points upgraded in 2021, would be scheduled for replacement in 2025. Looking forward, will OIT be absorbing the cost of future updates, upgrades, refreshes of technology that was originally funded through OEHRM or VHA?

Mr. RYCHALSKI. We are looking actually at a different model where we shift to sustainment of certain things being borne by the user, we have a working capital fund. I guess, if we could take that as a to be determined (TBD), we are looking at various models of how to fund sustainment and then the refresh going forward. As it exists today, OIT would, but I am not sure that that will be the case going forward.

Ms. LEE. Okay, great.

Mr. RYCHALSKI. Thank you.

Ms. LEE. All right. Thank you very much.

The CHAIRMAN. Thank you, Ms. Lee.

Mr. Meuser, you are recognized for 5 minutes.

Mr. MEUSER. Thank you, Mr. Chairman. Thank you all very much, Secretary, Under Secretaries. Thank you also for your significant progress over the last several years. It has really been quite remarkable, quite frankly. A few years ago, we were talking about all the issues facing the various VA hospitals and the admin-

istration as a whole, and now we are talking about if the funding is in the right arenas so as these improvements can continue.

Just a quick list that I have here of some of the progress and successes. Significantly improved veterans' trust in the VA, were there surveys done in that regard?

Secretary WILKIE. Yes, sir, we survey our veterans. We also survey our employees and why that is important—and I preach customer service, but I start off with customer service internally—if you do not have employees who are enthusiastic about coming to work, they are not going to give service to those they are supposed to serve. We have all employee surveys. That is why we have risen from dead last, 17 out of 17, to number 6 in terms of best places to work.

Mr. MEUSER. I see that, that is terrific.

Secretary WILKIE. If the Veterans of Foreign Wars (VFW)—one other thing, sir, I apologize—the VFW just did its national survey of its many millions members, 90 percent satisfaction, and also those 90 percent are recommending that those veterans who do not use VA come into the system.

Mr. MEUSER. Okay. Again, terrific. Near record low veteran unemployment, we do hear that. Any comment on that?

Secretary WILKIE. Yes. It is one of the best news stories in the country that is underappreciated. I have been able to go to the largest companies in the country, as well as mom-and-pop shops, and preach that veterans are the best value for the buck, particularly our young veterans. They can come in and look you in the eye and talk to you. They have also probably made—those who have stayed in the service to the age of 25 or 26—they have probably made more life-altering decisions in their short lives than most Americans make in a lifetime, and that is an incredible benefit to employers at whatever end of the industrial spectrum they are.

Mr. MEUSER. Again, outstanding. Expanded access to care in VA medical facilities and the community, as well as gave veterans more choice and greater control over their health care. Certainly, that was the mission of the MISSION Act. Is that proving to be as effective as you would have liked?

Secretary WILKIE. It is, but I have got to talk—I want to talk about a balance. It has been effective, we have put veterans at the center of their health care. If we can not provide what they need, they have the option of going to the private sector. Where we have seen the increase in traffic outside of VA is for specialty care, unique specialty care, but on the other side we have also seen record numbers of appointments within the VA. People are voting with their feet, they want to come someplace where people understand the culture and speak the language. It has created I think a wonderful balance in terms of our ability to serve veterans.

Mr. MEUSER. Great. Do you see a hybrid being the model, if you will, moving forward?

Dr. STONE. Absolutely. There are just with the remoteness of our population, with the geographic dispersion, there will always be VA at the centerpiece of care integration, but the utilization when appropriate of commercial health care systems to support. You know, today, we will see 315,000 veterans, we will buy about 80,000 visits

in addition to that, but 60,000 of those visits that will occur today are same-day visits inside our system.

In addition, there are 440 veterans that are seeing their primary care doctor that will have a warm handshake and handoff to mental health on same-day visits. One hundred and ten thousand visits last year were done as mental health same-day visits.

Mr. MEUSER. I have limited time, so I want to jump to this question. Access and transportation has been a concern of mine and I think would have great benefits from our suicide problem. Access to health care, certainly the hybrid model, gaining benefits and services within the community has helped. What are we doing as far as assuring that our veterans can get to the VA facility?

Dr. STONE. No. 1, we appreciate the VSOs that are helping us with that with volunteer drivers and donated vehicles. We are also working with the Walmart Corporation and the VSOs to get into communities both with direct face-to-face and remote visits. We have been working with Uber and Lyft to help fund in addition to our beneficiary travel programs. We are looking for any sort of innovative way to help the compromised veteran that can not drive on their own to get to us.

Mr. MEUSER. Okay, I will follow up with you.

Mr. Chairman, I am over my time, I apologize. I yield back.

The CHAIRMAN. Thank you, Mr. Meuser.

Mr. Cisneros, you are recognized for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman. Thank you, Mr. Secretary, and thank you all for being here today.

Dr. Stone, I just want to follow up on something that my colleague Mr. Pappas asked about the community care staff at the medical centers. You know, you said they are staffed and they are fully staffed, but I just visited Long Beach Medical Center, talking to them about this issue, and I know other individuals have kind of had some of the same experiences when they visit the medical centers, that the community care staff is overworked, they have too much work going on. What criteria are you using to determine that the community care staff is fully staffed?

Dr. STONE. It is really the staffing model that the Assistant Under Secretary has brought to us that we created the budget from, but let me say this: I think you can find areas in this country that are overworked, I think you can find other areas in the country that we are doing pretty well, but we have seen substantial growth in specialty care in the community. What we are not seeing is that kind of same growth in primary care or mental health, as the Secretary has referenced. I would be happy to take a look at that market and see if we are off-kilter and, if we are, we will staff it up. We have adequate resources to staff to where we need to be.

Secretary WILKIE. I would add, and I think Dr. Roe would appreciate the comment, your area of the country, the chairman's area of the country, is exploding in terms of veterans population. Part of the need that you have identified, I believe, will be addressed in the AIR reports and the market assessments.

Mr. CISNEROS. All right. I want to ask about a couple other staffing questions, this one particularly regarding the vocational rehabilitation and employment program. I am pleased to hear that, you know, you are reaching your goal or you will soon reach your goal

of one counselor to every 125 veterans that are enrolled in this program, but is that ratio based on a national number or is it more local? You know, is every center—are there are going to be some centers, especially in more metropolitan areas, where, you know, they are not going to have the 1-to-125 ratio?

Mr. LAWRENCE. Sure. You are right, last year at this time when you and I bantered we were in the process of hiring sufficient counselors to reach that goal and we have. We have done both, we made sure at a national level and at a local level, we have shifted some things around. Like Dr. Stone pointed out, we are always monitoring that, that is required by law. We would like to do some more study, because as you and I talked in your office, this is one of the most popular programs and it yields some of the best benefits for our veterans.

Mr. CISNEROS. Right. The one thing I will—the concern I still keep hearing about, though, is the constant turnover of the counselors, they are being shuffled around. You know, a veteran is there, they work a relationship, they build a relationship with the counselor and then, boom, that counselor is moved and they do not even know, and then they are having to start all over again, you know, giving them their new information. I mean, why are we still kind of seeing this kind of turnover where people are constantly changing around and moving?

Mr. LAWRENCE. Sure. Since you and I talked about this, we have done several things. I think your feedback was one around the consistencies of the outcomes and all of the counselors. There is sort of several things happened, one is sort of the kind of things you are hinting at, which is it should not have happened that way, the other is, of course, a very hot job market, as the Secretary—people leave us, we have to balance. Then we also do, in connection with your first question, we re-balance the load to get people more attention. We try not to do as much of that as perhaps you are seeing.

Mr. CISNEROS. Okay. In the budget, Secretary Wilkie, it indicates that the Veterans Benefit Administration is going to relocate 166 full-time employees to the Vocational Rehabilitation and Employment (VR&E) program. All these full-time employees focus on—well, are the employees focused on administrative help or are some of these going to be counselors?

Mr. LAWRENCE. A little bit of both. We are trying to centralize some of the administrative tasks, so that we can actually free up more counselor time and, in addition, hire some more counselors.

Mr. CISNEROS. One other request I have, and if we can work this out, you know, I have several colleges in my district, a lot of them veterans are going, attending these schools. One, Mount San Antonio College, has an Memorandum of Understanding (MOU) for the VetSuccess on Campus (VSOC) program. It would be great if we could build in these memorandums of understanding for these other colleges as well. It is a great service at Mount San Antonio College, but the other ones, you know, being based in Orange County, have to go to the L.A. VA in order to get that support and they can not get it on the local level.

On what grounds or what are we doing to kind of try and change this to make more local MOUs, so the veterans can get local service?

Mr. LAWRENCE. The VSOC is one of our most popular programs, every school is asking for it. We are looking internally, we started this a little while ago, at a project to figure out where to find the resources to get counselors on as many campuses as we can. I am happy to come talk to you about that.

Mr. CISNEROS. All right, I appreciate that. Thank you very much and I yield back.

The CHAIRMAN. Thank you, Mr. Cisneros.

Mr. Steube, you are recognized for 5 minutes.

Mr. STEUBE. Thank you, Mr. Chairman. I want to thank each and every one of you for your service to our Nation and what you do for our veterans.

Just as a quick bit of background. I served 4 and a half years active duty, Operation Iraqi Freedom, 25th ID, I did a tour over there. I am a disabled veteran, I am 70 percent disabled, it took me 11 years to go through the appeals process to get that designation. I have obviously been on this committee for over a year now and have reached out many times, Mr. Secretary, to your office, still have not been able to get on your calendar, so my—well, let me say something first and then I will ask a direct question.

I have town halls in my district and I have a very large population, I represent Southwest Florida, of veterans in my district. We live—most of my district is in a very rural area, so the nearest hospital is like a 4-hour drive, 3-and-a-half-hour drive. Every town hall I have, both telephonic town halls and in-person town halls, by far, unequivocally, veterans' issues are the biggest challenge in my district. I just had a town hall in-person in Sebring, I would say 65 percent of the issues brought up were challenges that these individuals were facing with the VA, not good challenges that they were facing, not positive things. We had a tele-town hall not too long ago and one of the individuals in the tele-town hall said that it took him over a year through the Charlotte clinic to get hearing aids. This is somebody service-connected disabled.

There are a lot of issues that are affecting my district. My constituents voted me up here to represent them on these issues and I would like to know who I need to contact to get on your calendar to talk about all these issues—

Secretary WILKIE. Well, I—

Mr. STEUBE.—because, quite frankly, 3 and a half minutes is nowhere near what I need to go through the litany of things, from the claims process that I have gone through personally, the appeals process that I have gone through personally, the health care issues that are directly faced in my district. We were supposed to have Sitterly come down, he canceled. We were supposed to meet with you in September, that got canceled. He was supposed to come to the district, that got canceled. It has been over a year. I am trying to serve my district and there are real, real challenges in the VA. We are blessed to have districts like the district in Ranking Member Roe's district where he has got a great hospital, great facility, and the treat for VA is great. I am on the opposite end of that spectrum where we do not even have a hospital in my district and we

have a few scattered clinics, and those clinics can not handle anything.

They bring in some things, the implementation of the MISSION Act in some areas of the country has been tremendous, in my district it has not, and there have been a huge amount of challenges.

I just want to know who I can contact in your office to sit down with you and go over these issues.

Secretary WILKIE. I am happy to do it. I wish I could answer as to why the schedules did not meet up, but as evidenced by some of your colleagues, I have been in a lot of their districts, I am happy to go. My family is in Tampa, so I am close by. But, no, just have your scheduler call my office and we will get together.

Mr. STEUBE. Okay. Well, we have done that several times, so that is why I am asking now again.

I will ask one very basic question that has come up and it is related to third party insurers. You know, all of us are interested in prompt payment by the VA of bills submitted by outside providers for community care, do you believe that the VA also should be interested in collecting every possible dollar that is due to the taxpayers for services that are provided in VA facilities and covered by third party insurers?

Secretary WILKIE. Oh, absolutely. Yes, sir.

Mr. STEUBE. Do you believe that the VA should be utilizing the same collection procedures that private sector providers use today?

Secretary WILKIE. I do not know what the regulations would be, but the first—your first question is right on target, we should be. I do not know what the procedure would be—

Mr. STEUBE. Well, the numbers that I have seen, I mean, the graph is kind of skewed. Like the numbers of things that we should be collecting and that are not getting collected by third party insurers I think would really help solve some of our budgetary issues—

Secretary WILKIE. I agree.

Mr. STEUBE.—that we face. I just want to make sure and if there is legislation that we need to do on this side of the chamber to make sure that that happens, I am happy to work on that.

Mr. RYCHALSKI. I can speak to a little of that. I think one of the big challenges they have is people self-disclosing that they have other health insurance. I think some people feel like, if I disclose it, my premiums are going to go up or something like that, the same thing we have experienced in the military health system. I, as the Secretary and I have some experience with this, agree that we should absolutely pursue that, it is just a matter of how aggressively we go after it. And I do not know that we should—we play all the commercial tactics. I mean, I think that we are dealing with the veteran population as well, so I think we have to look through that lens as well.

Mr. STEUBE. Okay. Thank you guys for being here today. I will follow up with your office.

I would yield any remaining time to the ranking member, if he has any questions; if not, I yield back to the chair.

The CHAIRMAN. Thank you, Mr. Steube.

Mr. Sablan, you are recognized for 5 minutes.

Mr. SABLON. Thank you very much, Mr. Chairman.

Mr. Secretary, welcome.

Secretary WILKIE. Good to see you, sir.

Mr. SABLAN. I apologize that I was not exactly friendly when you first walked in and I have my reasons for that, Mr. Secretary.

One of the goals of the community health care listed in the documents was to award and implement the new community care network contract in Region 5 and implement a new direction in Region 6. Region 6, of course, covers the Northern Marianas, American Samoa, and Guam, one of the highest enlistment per capita in the Nation.

The Department's decision to run the community provider program for the Pacific Territories is described as a new direction. Mr. Secretary, when we met over lunch, you promised me that you were going to do everything you can to help me. This decision has in fact, Mr. Secretary, is a return to the old system, the ones which slipped through the chains and the need for Choice Program. How does the Department intend to ensure the problems from the old system do not come up again in this new direction for Region 6 veterans, for my veterans, for those in American Samoa, for those on Guam?

Dr. STONE. Sir, what we found was that in Region 6 there was such a low number of providers trying to get a third party administrator to really administer that was ineffective and we felt that we could serve the veteran population better by directly contracting with the providers that are so geographically dispersed across your area.

Mr. SABLAN. Thank you. You are saying that we are going to—but I am correct, we are going back to the old system where veterans deal directly with VA?

Dr. STONE. I am saying that—

Mr. SABLAN. In my district, sir—

Dr. STONE.—the providers will deal directly with us—

Mr. SABLAN. Sir—

Dr. STONE.—in our delivery system.

Mr. SABLAN. Okay. In my district, sir, we hired—or VA hired a social worker, it took VA longer to get that social worker to report to work on its first day than it took for that social worker to retire from his position, you know what I am saying? It took your department longer to get that guy to come to work on his first day than when that guy had left because he is retiring.

Now, that is the kind of service, sir, we are going to—you know, we take these young men and women, put them in uniform, send them off to war, and give them a promise that we will forever take care of them for their service. I talked to a veteran just last Thursday who is now home, there is nothing else that they can do for him, I talked to him, he has cancer, and he goes in and out of the hospital, he goes in and out to get his painkiller medication that are so powerful that they can not give it to him at home because it could be dangerous.

I have many questions. So not—the reason given is not enough interest to proceed, what exactly is meant by not enough interest to proceed?

Dr. STONE. The size of this market is so small as far as the number of veterans that are in it that the third party administrators,

we felt we could administer better directly. Now, I am respectful of the fact that you know this market better than we do and, if you think that is a bad decision, we would be happy to sit with you and talk through it. But our goal is the same and that is to serve the veterans in this area. Both the Secretary and I are veterans, both of us have had deployments, we understand the pain of this, but we felt that we could deliver care more effectively by directly contracting with your providers than going through a third party.

Secretary WILKIE. I made a commitment to you, and I expressed this to the chairman, that my focus on the continent was Native populations, Native veterans, and then the Pacific. I visited Marianas, as you know, you were a gracious host. I promised you and I promised the chairman, I have to be more creative. I have to be more creative in getting our partners in the Department of Defense out to the Marianas and expand also, and I spoke to the Governor of Guam about this a week and a half ago, expand our VA presence in Guam as the naval hospital expands.

We are being—trying to be very creative.

Mr. SABLON. Yes. I am so envious, you know. The gentleman here is complaining that he does not have a hospital, but he has got several Community Based Outpatient Clinics (CBOCs). I do not have a CBOC. I do not have a vet center. You guys were talking about programs, care givers—those are not available in my district because VA will not put staff in my district to take care of veterans who are getting old, who need hospice care or who need people to come visit them at their homes. I have got nothing except for a fee based doctor who is available twice a week to see 400 veterans or almost 500. We have to figure something out better than what we are giving these veterans.

Sir, when they put on a uniform, they are as much American as you are. Yet, when they get wounded and they go to the islands, they are only half an American. It is enough that they do not vote for their commander-in-chief, sir, give them some decency.

Secretary WILKIE. Well, I have been very clear that the veterans of the Northern Marianas, Guam, and American Samoa serve in numbers in the Armed Forces greater than any other communities in the country, with the exception of native communities in the continental United States. I have made a commitment to do as much as I can.

Last thing about my last visit to the Northern Marianas, I looked at and talked with the hospital provider in your district on your island to enhance our partnership there. I have had long discussions with United States Indo-Pacific Command (INDOPACOM), the command out of Hawaii, to bring folks in, their people, their ships to help with caring for veterans on your island, and also as I said, expanding the closest large veterans facility to you on Guam to service veterans on both islands.

It is something I have worked on. I showed my commitment by coming to see you, also going to Samoa and also going to Guam. I hope to be out there again, but it is something that we are working hard on. I wish I could make it go faster.

The CHAIRMAN. Mr. Sablan, we are—

Mr. SABLON. My time is up, Mr. Chairman. Thank you very much, Mr. Secretary.

The CHAIRMAN. Mr. Secretary, I hope that—I do grant your sincerity and I know you have traveled there, and so has the committee, and I share Mr. Sablan’s frustrations, and I know you are frustrated. I encourage you to engage with us on a solution.

Secretary WILKIE. I agree with you, sir. Yes.

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

Mr. BARR. Thank you, Mr. Chairman. Thank you, Secretary Wilkie, Dr. Stone, and our other witnesses for your service to our veterans. Obviously with Mr. Sablan’s line of questions and Mr. Steube’s line of questions, there is work to do. There are problems. I do want to just note for the record, my appreciation and my colleagues’ appreciation for the president’s budget request, \$243 billion, a 10.2 percent increase above the 2020 enacted levels. I will note that the testimony that you provided again that the VA’s budget has increased more than \$60 billion or 33 percent since 2017 under this administration’s leadership. The fact that the 2021 request would support 404,835 full-time equivalent employees at the VA, an increase of nearly 15,000 above 2020, and then more than 33 percent of those employees are veterans, I think that is an indication of the commitment that the Trump administration has to the VA, and I think it also dispels the myth that this administration is interested in privatization.

I think that those basic facts run totally contrary to this narrative that somehow this administration is moving toward privatization. Clearly not when you have that much of a significant increase in funding and employment at the Department. I appreciate this administration’s promises made and promises kept approach to our veterans.

As my colleagues have noted, there are challenges that remain. As we all know, the opioid epidemic is an issue that has touched every community in the United States, and especially in my home State of Kentucky. According to the CDC, Kentucky is among the top ten states with the highest opioid prescribing rates.

I was encouraged to read your testimony. The efforts that the VA has taken to reduce the reliance on opioid medication for pain management, you note that alternative therapies like whole health, that are important to components of the VA’s pain management strategy. As you know, I have been a strong advocate of these alternative therapies, like acupuncture, equine-assisted therapy, adaptive sports. In the 2021 budget request, I will note that unfortunately funding for the VA’s whole health initiative did not increase, and neither did funding for the adaptive sports program.

My question is why is the funding stagnant if this is, in fact, an effective method of getting veterans off of opioids?

Dr. STONE. Sir, you have recognized accurately that we have led the Nation in reduction of opioid use. Our actual opioid use disorder patients have actually from 1918 to 1919 actually went down. We just had a session in which we took a look at the use of whole health in the reduction of opioids in other pain medicines and found that if we added whole health techniques, tai chi, various cognitive efforts, yoga. What we found was an additional 38 percent reduction in pain medicines.

Now, what you are seeing in the budget is we really believe it is time, instead of having us sitting off to the side, that we integrate into our packed team models, our care team models the capability to do this work. That is where, although you see it is stable in the budget, it is actually a reflection of an evolution in how we are approaching whole health techniques.

Mr. BARR. Well, thanks for your efforts on opioid avoidance and I will just note for the record, my interest in the whole health, and the adaptive sports, and all of those alternatives. The appeals backlog, obviously we appreciate the \$24 million increase for the Board of Veterans Appeals above the 2020 enacted budget. We know that you have good intentions to address the pending Legacy appeals. I will tell you from my case work that despite the Appeals Modernization Act, and it has helped. We know that Appeals Modernization has helped. We still, though, have a problem with the Legacy appeals in our case work. We are seeing 3 year delays.

Can you tell us what is the biggest factor causing that delay and what are we learning, and when are we going to get to those Legacy appeals? Because that is impacting my veterans.

Dr. LAWRENCE. Sure. The Appeals Modernization Act, as you point out, is a great success. Let me sort of talk a little bit in the details. Over at the Veterans Benefits Administration, we process Legacy appeals, and those are generally resolved, but some can go to the Board of Veterans Appeals. The increase you describe is for more judges and more support to actually process their way through that.

We are experiencing the last sort of part of the new beginning, if you will. You are right. This is a big focus. I know the board is thinking about not just in person hearings, but tele-hearings, and every kind of way to work that off. I believe they said this will be done by 2022, but I will be happy to arrange for them to come and talk to you about it. They know this is a very important effort.

Mr. BARR. Thank you. I am over my time and I appreciate your service and your work. I yield back.

The CHAIRMAN. Thank you, Mr. Barr. Ms. Underwood, you are recognized for 5 minutes.

Ms. UNDERWOOD. Thank you, Mr. Chairman, and thank you, Mr. Wilkie, and everybody for joining us today.

In the last 20 years, the number of women veterans coming to the VA for health care has tripled. This includes mental health care. In the next 20 years, that number is projected to double again. Too many American women are struggling to get quality, affordable health care. Gaps in our health care system and in our health care workforce are a big contributor to that.

Finding and retaining staff is a challenge across the system at large, and it includes the VA. Secretary Wilkie, VA staff shortages for gender specific care are concerned, and one that you all outlined in your budget request, will this budget get us to a place by the end of the year where the gap between supply and demand is closing, not continuing to grow?

Secretary WILKIE. I do believe it will begin to close. We, in this last fiscal year, just trained 7,000 more health care providers for women-specific care. We are seeing—we now have two health care

professionals in each of our centers who deal specifically with women's health. That is part of the change.

I do expect that the percentage of women veterans who are coming to VA to grow, we are now thankfully up to 41 percent enrolled, 84 percent satisfaction rate of the women veterans who use VA. It is a massive cultural shift. Be real quick, when I was born, my father was in an army that less than one-half of 1 percent were women. As the undersecretary of defense under General Mattis, I was responsible for a force that was 17 percent women for VA.

Ms. UNDERWOOD. Right.

Secretary WILKIE. That means 10 percent of our population.

Ms. UNDERWOOD. Sir, you said 7,000. You were training 7,000 clinicians, I am assuming—

Secretary WILKIE. Providers and nurses, yes.

Ms. UNDERWOOD. Okay. They are general practitioners, not to be offering gender-specific care; is that correct?

Dr. STONE. They are providing gender-specific care in many residencies. Let me give you an example of that. As part of this budget, we will train 450 mental health providers in gender-specific care for women veterans.

Ms. UNDERWOOD. Right. I guess what I am trying to delineate between is the general practitioner who might take care of women versus someone who is there to take care of women for their whole Full Time Equivalent (FTE).

Dr. STONE. As we grow, we will—that is why we are doing the mini residencies of repurposing the workforce. There is not a gender-specific workforce out there that we can effectively hire, and therefore, we are training ourselves to get there, and we will re-dedicate that workforce as we get there.

Let me give you an example of that. We make the diagnosis of breast cancer about 500 times a year in the VA. We have about 2,900 active breast cancer patients.

Ms. UNDERWOOD. Right.

Dr. STONE. Those are disbursed across the system so much that I can not have a dedicated full-time breast cancer surgeon, and a lot of that work goes out.

Ms. UNDERWOOD. Okay. The VA is required to ensure that all women veterans that you have and you serve are assigned to women's health primary care provider, but right now only 78 percent have one. Will the budget close that gap by next year?

Dr. STONE. Yes.

Ms. UNDERWOOD. Okay. The president has recently submitted a supplemental appropriations request to respond to the Coronavirus. This package does not include any specific funding to assist VHA facilities in the event that they need to respond to Covid-19 cases. Given the diverse population of patients that the VA facilities interact with on a regular basis, it is obviously something that we need to ensure that we are planning for. Secretary Wilkie, what steps is VHA taking to ensure that veterans have the information that they need to keep themselves and their families safe?

Secretary WILKIE. Well, thank you. VA is the foundational response force for national emergencies. Every year, we prepare and deploy for hurricanes, for earthquakes. We regularly train for out-

breaks of viruses, medical emergencies. We have been—we do not need any extra money now.

Ms. UNDERWOOD. Sir, I am not asking about the money. I am asking about what are you doing to share the information with the veterans and their families.

Dr. STONE. We have had—we are subordinate to HHS in communication with the American people, and we have not gotten in front of that. We have had a series of missives that we have sent to our workforce, as well as we have been rehearsing all of our response systems. We have not directly communicated to the American veterans separate from HHS.

Ms. UNDERWOOD. Okay. Even if it is not going out under a VA letterhead, have you sent anything to the veterans in your care about Coronarius?

Dr. STONE. No.

Ms. UNDERWOOD. No. Okay. Is that something that you all are planning to do in the weeks to come?

Dr. STONE. As we watch this and respond to this, yes.

Ms. UNDERWOOD. Is that something that has been part of your plans for pandemic response, that would include direct response from the VA, as their provider, to that veteran that they serve?

Dr. STONE. Yes. This is part of a response that goes back to ebola—

Ms. UNDERWOOD. Right.

Dr. STONE.—in the early 1990's. Each of our hospitals has a response system that includes communication with veterans.

Now, let me correct my answer just slightly. We just had a discussion with a number of the VSOs yesterday or day before regarding this and what we were doing, and what we needed from them when we begin directly communicating.

Secretary WILKIE. To add to that, because we have been through these things before, we are looking at our supply chain. We are looking at our processes to prepare in the event that we are called on.

Ms. UNDERWOOD. Okay. I know my time has expired, Mr. Chairman. I would just like to urge you to recognize that we are on the precipice of a significant public health crisis in our country, meaning the arrival of Coronarius at pandemic levels in the United States.

You all know, as well as I do, that the VA is the primary care provider for a lot of individuals. Your providers are the trusted health care source that these individuals are interacting with. I would urge us to take a proactive public health response to manage that risk communication. They are not going to get it from anywhere else, and so let us not hide the ball here, sir. Thank you. I yield back.

The CHAIRMAN. Thank you, Ms. Underwood. Mr. Steube, you are recognized for 5 minutes—Mr. Watkins, I am sorry.

Mr. WATKINS. Yes, Mr. Chair. That is all right. Well, that is Okay. Thanks to you all for being here. Like Mr. Steube, I am also a disabled veteran and I receive my health care through the VA. I have got a bone to pick with you all. I say that lovingly.

I got a surprise bill and I was referred to community care outside the VA system in my home of Topeka, Kansas to a hospital called

Stormont Vail. I know Stormont Vail well because my dad has been a doctor at it for 40 years. He has also been on the board of directors at Stormont Vail.

The VA, I know all of those people quite well. I have lived in Topeka almost my entire life. I do not know how to solve this thing, man. I have called, and sat on hold for 25 minutes at a time, and been bounced around to other recordings and things like that. I can not seem to solve this surprise bill.

Imagine that, because I know the VA system well. I know my doctors in the VA system well. This is my community. I have been a member of the greater Topeka medical community for my whole life, since I was six. I was referred to Stormont Vail, where my dad is on the board of directors. My dad is an endocrinologist, the very type of doctor whom I saw. There is this surprise bill. I can not solve it. I am in the U.S. Congress. Moreover, I am in the VA Committee, and the subcommittee that deals with electronic medical health records.

I do not say that to make you feel uncomfortable. I said it because we are users of these systems. We are not in a bubble. Just like Greg said, we are dealing with this personally ourselves and it is one fight, and I thank you for continuing that fight. We have got a long way to go.

Mr. Secretary, good to see you again, sir. The president's budget request of \$90 million more to expedite the implementation of the Cerner Scheduling System, I think it is great. The medical centers in my district were slated to get the new system in 2025.

We had a hearing about scheduling implementation last year, and it is clearly a great system, a much better improvement over Vista. With this acceleration, when can Eastern Kansas expect to see this modernized scheduling system?

Secretary WILKIE. The goal is to have scheduling components by 2024, all in place.

Mr. WATKINS. All right. The VA has invested a significant amount of taxpayer funding to develop a modernized claims processing system for the Board of Veterans Appeals, called Case Flow. What is VA's timeline to sunset the board's Legacy system?

Dr. LAWRENCE. We do not have anybody from the Board of Veterans Appeals here with us today. We can arrange for a follow up to make sure you get the information.

Mr. WATKINS. All right. That is all I got. I yield the remainder of my time. Thanks for your efforts.

The CHAIRMAN. Thank you, Mr. Watkins. Well, we are coming to the conclusion of panel one testimony.

Mr. Secretary, I want to thank you for appearing before this committee to testify on the budget. Before we leave, I do want to reiterate Ms. Underwood's plea that the VA carefully, how we prepare for an impending public health crisis, that VA does have a fourth mission, which is not just about our veterans. It is also about, as you said, being there for national emergencies. This, I think, is emerging into a national emergency.

We ought to think—Dr. Stone, you talked about standing up testing capacity, and I think we will discuss this more. Before you leave, I do want to address another important issue, and that is the issue of sexual assault and harassment at our various VA facilities.

We do need to make some cultural changes to improve the care of our women veterans to make them feel welcome. In making the cultural changes necessary to make the VA an inviting place for our increasing number of women veterans will require leadership from the top. One in four women in the military experience military sexual trauma during their service. At least one in four women veterans experience sexual or gender-based harassment at VA facilities.

Just because a medical center has a low complaint rate from women veterans, it does not mean that sexual harassment is not occurring at those facilities. It may mean that women just do not feel safe and comfortable coming forward.

It is counter-intuitive that we may actually in the interim, in the short term, actually want to see more complaints being lodged at our medical centers. These are some of the issues that I hope that we will discuss at a future planned hearing—a hearing that I plan to schedule on this topic.

What I want to know from you, Mr. Secretary, is will you commit to working with my staff to ensure that you personally appear at this hearing?

Secretary WILKIE. Yes, sir.

The CHAIRMAN. Thank you, sir. I appreciate that. With that, first panel is excused and ready to bring forward the second panel. Thank you.

We will take a brief bathroom break, 5 minutes. A recess and people may do what they want to do on this recess for 5 minutes.

[Recess.]

The CHAIRMAN. If we could take our seats and I would like to get panel two started. If panel two could take their seats.

I would like to call the committee back to order and is Melissa here? She stepped out. Okay. Adrian is here. All right.

I now invite our second panel to the witness table. We have seated at the witness table Mr. Adrian Atizado, Deputy National Legislative Director of Disabled American Veterans on behalf of the Independent Budget, accompanied by Mr. Carlos Fuentes, director of the National Legislative Service of the Veterans of Foreign Wars, on behalf of the Independent Budget; Mr. Morgan Brown, National Legislative Director of the Paralyzed Veterans of America, on behalf of the Independent Budget; and I know that Melissa stepped out, Melissa Bryant, the National Director of the American Legion on behalf the Independent Budget. I expect Melissa to take her seat shortly.

Let us get this going. Mr. Atizado, you are recognized for 5 minutes.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Chairman Takano, Ranking Member Roe, and members of the committee, the co-authors of the Independent Budget, that would be Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), and VFW, we are certainly pleased to present our Fiscal Year 2021 funding recommendations for the Department of Veterans Affairs, including advanced appropriations for Fiscal Year 2022.

I heard a little bit of discussion earlier with the first panel about the increasing resources that is going toward the Department of Veterans Affairs. I understand to the untrained eye, the overall veteran population is decreasing in light of the increasing amount of revenue, or I am sorry, resources going to VA, but as we all understand, the public may wonder why VA's budget, in fact, continues to increase.

Simply, it is just that less than half of all veterans come to VA for their own benefits. For those that do, their numbers increase year over year, and the investments made in VA represents a continued commitment to care for those veterans, as they have honorably served and sacrificed in defense of our freedom.

Our own Fiscal Year 2021 budget estimates affirm that these needs continue to grow. The Independent Budget (IB) recognizes the work done by Congress to secure stable and predictable funding for VA by appropriating in advance \$1 billion in discretionary dollars. We would like to recognize the administration's request for VA, which provides 12, 13 percent increase, which is fantastic. Unfortunately, when we review this request, we believe it does fall short in meeting true needs of America's veterans in light of pending requirements that Congress has put on VA and other requirements VA is putting on itself to serve our Nation's veterans better.

For Fiscal Year 2021, the IB recommends \$114.8 billion in total discretionary budget authority for the VA. This recommendation is \$4.4 billion more than the administration requested, and it is about \$17.3 billion more than the current Fiscal Year that we are in, 2020.

Most of this increased funding recommendation goes toward veterans' medical care, about \$13.6 billion of that. Of this increase, about 85 percent, or \$11.8 billion would go toward in-house VA care. This large increase is driven by our current services estimate reflecting the impact of projected uncontrollable inflation on the cost to provide services to veterans that are currently using the system. The estimate also assumes the baseline 3.1 pay raise, which Congress enacted back in December 2019, and a projected increase of about 65 new enrollee and unique patients.

We also recommend an additional projected medical funding needs for VA of nearly \$2.1 billion for a handful of programs, including VA's prosthetics and sensory aid services, the women veterans' health care, VA's comprehensive care giver support program, and to close the gap on VA's reported vacancies for outpatient mental health and primary care.

VA's construction accounts is another major VA account the IB recommends additional funding. We recommend a total of \$3.9 billion, which is a \$2.1 billion increase over current funding levels to address serious construction needs.

Finally, the IB is recommending an increase of \$1.2 billion to continue developing and deploying VA's electronic health—medical record, and separately deploy VA's—a new VA scheduling system in advance of the 5-year that has been portrayed. We would like to see that scheduling system come out faster than is being requested, simply because not only does it provide operational efficiencies, it provides a lot of satisfaction and less turnover rate for the facilities than the VA staff that use that system.

Chairman Takano, Ranking Member Roe, we recognize the administration's budget request contains numerous legislative proposals, and the IB would like the opportunity to work with you and your staff as the committee considers each of these proposals to ensure veterans' interests are at the forefront.

For example, the IB opposes four benefits related proposals that would reduce benefits or limit veterans' access or their survivor's access to their own benefits. Other proposal, though, we support, such as the one regarding VA's medical foster home program.

This concludes our oral statement, and on behalf of the millions of veterans the IB VSOs represent, we want to thank you for this opportunity to testify. My esteemed colleagues from PVA and VFW are happy to answer any questions you may have.

[THE PREPARED STATEMENT OF ADRIAN ATIZADO APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Atizado. I now call upon Melissa Bryant for 5 minutes.

STATEMENT OF MELISSA BRYANT

Ms. BRYANT. Thank you, Chairman Takano, Ranking Member Roe. Behalf of our national commander, James W. Bill Oxford, and the nearly two million members of the American Legion, we thank you for the opportunity to testify on the Department of Veterans Affairs Fiscal Year 2021 budget.

As VA moves forward to serve the veterans of this Nation, it is imperative that the secretary have the tools and resources necessary to ensure that veterans receive the services they are entitled to in a timely, professional, and courteous manner, because we have earned it.

The American Legion calls on this Congress to ensure that funding is maintained and is increased as necessary to ensure the VA has preserved and enhanced to serve the veterans of the 21st century and beyond.

I am going to go off script a little bit to reiterate for one comment that has been repeatedly brought up throughout the first panel, and that was the Agent Orange presumptives and reiterate that the American Legion supports for these Agent Orange presumptives to be given to these veterans who are waiting, because one of them is my father. That is something that I continue to use—or rather, I should say I share with the secretary in having a Vietnam veteran era parent, and knowing that his exposure to Agent Orange through his injury by punji spikes through his legs, is something that we know is traced to these ailments. My father being one of those veterans impacted by those Agent Orange presumptives, we urge for OMB and for others to ensure that those are tended to.

Beyond that, within our written testimony for the American Legion, we also speak to the 17 points that have also been talked about throughout today's hearing, to include mental health provisions for suicide prevention, for Post Traumatic Stress Disorder (PTSD), for Traumatic Brain Injury (TBI), and of course, going all the way through to women veterans like myself, and ensuring that we have the gender specific care that we require, provided to us by the VA through our earned benefits.

I will not belabor into those point in the interest of time, but I want to say that the American Legion appreciates the leadership of this committee and remains committed to ensuring that the VA has the necessary funds, the resources, and the staff to carry out its mission of caring for our Nation's veterans. We are committed to working with the Department of the VA and the committee to ensuring that we are provided with the highest level of support of care.

With that, in the interest of time, I am going to conclude my oral statement so we can move into questions and answers. Thank you, gentlemen, for your time.

[THE PREPARED STATEMENT OF MELISSA BRYANT APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Bryant. I will recognize myself for 5 minutes, and I want to quickly get into questions.

I am sure all of you have seen the \$53 million requested by the administration for the Prevents Task Force in Fiscal Year 2021. Just very quickly, yes or no, were VSOs appropriately engaged by VA in the Prevents process? Mr. Atizado, I will begin with you.

Mr. ATIZADO. Mr. Chairman, I can tell you that the last few meetings at the White House on the Prevents Task Force, we have not been invited, although we have been engaged with Dr. Van Dalen (phonetic) on her efforts.

The CHAIRMAN. Okay. Yes. Mr. Fuentes?

Mr. FUENTES. The VFW executive director, V.J. Wallace, is on the Prevents Task Force and we have been involved with the Task Force. No direct feedback on the exact monetary amount that they are requesting, though.

The CHAIRMAN. Yes.

Mr. BROWN. PVA has been invited and participated in the meeting. We have had some opportunity to make some input.

The CHAIRMAN. Ms. Bryant?

Ms. BRYANT. Likewise, the American Legion has been invited to the Prevents Task Force meetings. We have provided advice and counsel. Nothing further.

The CHAIRMAN. Very quickly. What is your understanding of how these funds, these \$53 million, will be used and do you know if your recommendations will be reflected in the final Prevents Task Force report released in March?

Mr. ATIZADO. Well, Mr. Chairman, I could not say until we actually see what the roadmap is and how that translates down to the different—across the agencies and secretary's priorities, we could not make any kind of commitment at this point, I think.

The CHAIRMAN. Go ahead.

Mr. FUENTES. Same for the VFW. We will have to evaluate, but it looks promising.

Mr. BROWN. Same for PVA.

Ms. BRYANT. Likewise.

The CHAIRMAN. Great. Thank you. The Independent Budget notes that institutional cultural change from the top is necessary to create a welcoming environment and ensure high quality care for women veterans. In your opinion, what actions should VA take that it is not currently taking to facilitate this cultural change? Why do not we begin with Ms. Bryant.

Ms. BRYANT. To your comments earlier, Mr. Chairman, we believe that the VA needs to seriously consider its end harassment campaign, and starting with setting that cultural competency for women as we enter the facilities in knowing that we are welcomed, and knowing that our services is recognized. That is something that VA one, needs to continue to enhance, appreciate the secretary's comments earlier in that they are looking at their bystander policy and how they would continue to help those who are perhaps feeling uncomfortable within the main spaces of the VA.

We appreciate that the care that is provided in the women's clinics is outstanding, depending on the facilities that you attend, such as the DC VA where I attend. However, we also know that all facilities are not created the same. Ensuring that we are not harassed in other parts of medical facilities, doubling down on the end harassment campaign, doubling down on gender specific care, not so much general practitioners who provide pelvic exams or anything else that would be for a woman, but more gynecologists and those who focus on gender-specific care. Those are steps that the VA needs to continue to push upon.

The CHAIRMAN. Would anyone else like to respond?

Mr. FUENTES. I would like to add as well, this committee and this body has passed the Debra Sampson Act, which will significantly improve care for women veterans. The Senate needs to do that. We are hopeful to work with you to secure Senate passage.

I also want to add that women veterans choose the gender of their provider. Not all women veterans want to get care from a women's clinic, but not all women who want care from a women's clinic are able to get that care. Privacy and gender competencies of all service lines is also an issue that needs to be addressed.

The CHAIRMAN. Great. Thank you. Thank you. I want to move on to a question about infrastructure. The Independent Budget requests a much higher budget request for infrastructure. Quickly, how would you prioritize VA's needs on infrastructure?

Mr. FUENTES. If I may, VFW believes that—IB believes that VA has a pretty large, over \$60 billion IT issue, I am sorry, infrastructure issue, and they are just chipping away and not chipping away as much as they can. There is a \$7 billion backlog on—corrections, which is related to safety, making sure that these facilities are safe for veterans who are using them.

That would be the priority, looking at the safety, but also the access caps. VA can hire all 50,000 vacancies or fill them today, but they would not have places to put them. That is going to be a real big issue.

The CHAIRMAN. All right. My time is up. Dr. Roe, go ahead. You are recognized for 5 minutes.

Mr. ROE. Thank you. Let it be known that I sent in my American Legion dues late, but I doubled the amount. How is that? I sent in twice as much I was supposed to.

Ms. BRYANT. We appreciate that. You are paid up for second life then, sir.

Mr. ROE. Matter of fact, a little more than double. Interestingly, when the discussion a minute ago was on the gender issue, it took me back to my time in the military, and I served in the second infantry division at Camp Casey, Camp Bradley, and then down in

121 Evac in Seoul. Until I was at the 121 Evac hospital, there was not a single—I do not remember a single female in the second infantry division, and I think I would have remembered that, which is how the VA has changed.

It literally was all a male organization. I mean, it was set up for men. I never thought about it when I got here because my office, as an OBGYN doctor, was all set up for women. I just made the assumption that it was all set up. It is not. You are absolutely right. I have traveled to I can not tell you how many VAs now, and some of them really have excellent facilities, gender-specific facilities. They really are good.

The problem of staffing up is a problem, because of our shortage of medical providers around the country. I think VA is going in the right direction. Certainly when I heard Dr. Stone last—a couple of weeks ago we had breakfast with him, that now 41 percent of eligible female veterans are going to a VA, that is a good number, and 48 percent of eligible men are going. That is almost a parody now. That is a good thing. I give them a shout out for that.

I hear you loud and clear. I think the VA understands that and wants to get moving. Here is—I know we went through hours of discussion when we talked about the MISSION Act. All of you all sat around a table. We talked and debated back and forth about the construction needs. I think one of the things we are going to need your help on is that, because the VA is going to have to transform the way it is doing business. As you mentioned, the \$60 billion, if we begin to make those capital improvements, it has got to be done right. Whether it is through leasing, building, I do not know what it is going to be, but when those market assessments come in, and let me tell you, this is going to be hard work that nobody gets—you know, if I go in and say to the local Kiwanis Club at home, “I am going to talk about the air infrastructure,” they are going to run for the exits.

We are going to have to do the hard work, and it is going to be up to you guys to help us do that hard work, and that is going to be, I think, the hardest part of the MISSION Act to undo to get the VA right sized. It is not going to be that every Congressman says, “Well, I have got to keep this hospital of four people in it open.” We have got to have enough courage, we do, enough courage to say, “No, that is not the way it is set up.”

I really do, I wish in a way I was going to be here another term or two to work through that, because it is not going to be easy and fun, but it is incredibly important about how our veterans, long after nobody knows who was on this dais serves, 50 years, 30 years from now. I mean, think about 2050. That is only 30 years away. The VA can not look in 2050 like it does today, because I can promise you, health care is not going to be delivered that way.

I am asking you right now, and I know you are—all of you all at the table were a tremendous help in writing this. The question is can we execute it, and do we, up here, the elected officials, have enough courage to do what we need to do. I will let any of you answer that. It is more of a statement, not a question.

Mr. ATIZADO. Ranking Member Roe, thank you so much for your commentary. We could not agree more. One of the critical aspects of the MISSION Act was, in fact, infrastructure review. The tim-

ing, though, I think is most important. The idea to do an infrastructure review after market assessment was done is critical, but the idea of a market assessment was to ensure that the underlying health care system is stabilized.

Now, what is happening here is we have a contract vehicle that does not quite align with statutory or regulatory requirements. You have got a third party administrator that is just stepping in, trying to lean real far forward to try and meet not only the needs but the gap in policy. We are still waiting for the network and the subsequent referral patterns for patients for veterans in and out of those networks, as well as a change in—responsibility under this new veteran community care program.

We are trying to wait for all of that to stabilize to a point where we can get a really better idea as far as what the workload, and the demand, and the need is going to be into the future. We will want those market assessments is to capture that. We do not want to leap too far forward and start tinkering with infrastructure, which this committee knows is very hard to deal with, decades. Right.

Mr. FUENTES. If I could—if I may, Dr. Roe, and thank you very much for your leadership on that specific part of the bill, that Member of Congress will insist that that facility stays is because his or her constituents, the veterans who are served by that, are not happy with the replacement plan. That is really going to be the lynchpin here as to whether this works or not. Unfortunately, we are concerned that the veterans we have asked have not been asked by VA what they would like to see, what type of improvements they would like to see, because ultimately, that has to be the center of it. When they went to Fayetteville and they said they did a market assessment, we asked our folks at Fayetteville, “Did VA ask you?” You know, “What is going on? They want to reform the infrastructure plan here. Did they ask you anything?” They said, “No.”

That is going to be an issue that needs to be addressed and we are hopeful that—I know you share that concern, so hopefully we can.

Mr. ROE. Okay. Thank you. I yield back, Mr. Chair.

The CHAIRMAN. Thank you, Dr. Roe. We are now at the close of our second panel’s testimony and questioning period. Again, I would like to thank the witnesses for their appearances and their testimony. We have heard your concerns on behalf of veterans and look forward to working closely with each of you.

All members will have 5 legislative days to revise and extend their remarks, and to include extraneous material. Again, thank you for appearing before us today, and this hearing is now adjourned.

[Whereupon, at 12:54 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Robert Wilkie

Good afternoon, Chairman Takano, Congressman Roe, and distinguished Members of the Committee. Thank you for the opportunity to testify today in support of the President's Fiscal Year (FY) 2021 Budget for the Department of Veterans Affairs (VA), including the Fiscal Year 2022 Advance Appropriation (AA) request. I am accompanied today by Dr. Richard Stone, Executive in Charge, Veterans Health Administration (VHA); Dr. Paul Lawrence, Under Secretary for Benefits, Veterans Benefits Administration (VBA); and Jon Rychalski, Assistant Secretary for Office of Management and Chief Financial Officer.

I begin by thanking Congress and this Subcommittee for your continued strong support and shared commitment to our Nation's Veterans. With the funding provided by Congress, VHA provides high quality health care services to 9.3 million enrolled Veterans; VBA provides educational benefits for over 900,000 beneficiaries and guaranteed over 624,000 home loans; and our National Cemetery Administration (NCA) will inter an estimated 137,600 Veterans and care for over 4 million gravesites in our 156 sacred National Cemeteries. We are on the other end of the national security continuum, as we take care of those who have already borne the battle, and I continue to believe this is one of the noblest missions in government.

Progress

Solid progress on some of the most transformational initiatives in VA's history has taken place in the last 18 months, with the result being a string of wins that puts Veterans front and center where they belong.

One of our most notable accomplishments is the near-flawless implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 signed into law by President Trump in 2018, giving Veterans real choice over their health care decisions. Emboldened by predictions of an imminent VA system collapse, we effectively rolled out this landmark legislation with no disruption to Veteran care. Less than 5 months after the rollout of the VA MISSION Act's community care provisions, VA had made more than 2.2 million referrals to community care. In addition, we implemented a new urgent care benefit and more than 90,000 urgent care visits had been completed in the same timeframe, and it is only becoming more popular with Veterans. In October 2019, eligible Veterans conducted more than 5,000 urgent care visits each week, thanks to the 6,400 local urgent care providers that have contracted to provide this benefit for VA.

Success with the VA MISSION Act had tremendously positive second and third order effects. Because Veterans like what they see, VA is delivering more care overall than ever before. In Fiscal Year 2019, VA completed more than 59.9 million internal episodes of care – a record high and about 1.7 million more than the year before. Even better, Veterans' overall trust in VA now sits at 72 percent, as compared to 60 percent in 2016. Statistics show:

- Eighty-seven percent of Veterans now trust the VA health care they receive;
- In a recent Veterans of Foreign Wars survey, nearly three quarters of respondents reported improvements at their local VA; and
- More than 90 percent said they would recommend VA care to other Veterans.

We expanded other venues of care for Veterans as well. VA is a leader in using telehealth technology to diagnose and treat Veterans remotely, by connecting Veterans with health care providers electronically, sometimes in their own homes. In Fiscal Year 2019, VA exceeded 2.6 million telehealth episodes of care to more than 900,000 Veterans. To increase access to telehealth services, VA has established multiple innovative agreements for 'Anywhere to Anywhere' connected care programs with Walmart, Philips, T-Mobile, Sprint, and Verizon. These partnerships give Veterans who may need help with Internet service more options to connect with VA health care providers through video telehealth.

We have also tackled some of our most pressing social issues: opioid use disorder (OUD), homelessness, and a regrettable scourge on our society: suicide.

President Trump's 2018 Initiative to Stop Opioids Abuse and Reduce Drug Supply and Demand directly contributed to a 19 percent reduction in the number of patients receiving opioids nationwide. Overall, since the President took office, there has been a 35 percent decline in Veterans being dispensed an opioid from a VA pharmacy.

VA has achieved impressive results in fighting Veteran homelessness by working with local governments, companies, and other stakeholders. In Fiscal Year 2018, the total number of Veterans experiencing homelessness decreased 5.4 percent, and in 2019, that number dropped another 2.1 percent. In the last two fiscal years, VA has helped 124,900 Veterans and their families by housing them or preventing them from becoming homeless. Thanks to these partnerships, we've seen 78 communities and 3 states effectively end Veteran homelessness.

The success of these partnerships suggests it's a good way to reduce Veteran suicide, and so VA adopted a public-health approach to suicide prevention, which focuses on equipping communities to help Veterans connect with local support and resources. The public-health approach is central to VA's first ever National Strategy for Preventing Veteran Suicide, which was published in 2018, as well as the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) Executive Order (EO) 13861. PREVENTS aims to bring together stakeholders across all levels of government and the private sector to address the national suicide epidemic and provide our Veterans with the specific mental health and suicide prevention services they deserve.

Our recent successes reveal the magnitude of change occurring at VA. But it is only part of the story because we have even more fundamental changes to how VA operates on the cusp of deployment. VA is on the verge of delivering its new electronic health record (EHR) solution at Mann-Grandstaff VA Medical Center (VAMC) in Spokane, WA, followed by VA Puget Sound Health Care System (HCS) in Seattle and American Lake, WA. Congress has made it clear, and I have always maintained, that we not rush to implement a new EHR at the sacrifice of the quality patient care we promised and are committed to delivering to our Veterans and other beneficiaries. VA identified that the new EHR solution requires additional systems configuration to execute planned user training at the Mann-Grandstaff VAMC in Spokane, Washington. As such, VA is not proceeding with the previously planned March go-live at this location. VA is taking every precaution to deliver an effective system for our clinicians and users, and we are committed to getting this absolutely right for our Veterans. Analysis has begun in earnest on the schedule impact of the user training shift, and we hope to have a revised and fully vetted schedule to present to key stakeholders in the coming weeks; with periodic updates provided as needed. After implementation at our initial sites, the new EHR will be delivered to over 1,200 VA hospitals and clinics through a phased deployment strategy. Concurrent with the deployment of our new EHR modernization is the installation of a new medical logistics system, the Department of Defense's (DoD) Defense Medical Logistics Standard Support (DMLSS) system. We are also deploying our new accounting and acquisition system, the integrated Financial and Acquisition Management System, to NCA with full implementation across VA following in the coming months and years.

The magnitude of change has been so great, and the pace so quick, that VA must carefully assess our resource needs to ensure we can adequately sustain what we have accomplished while continuing to make investments in key areas that promise the greatest return for our dollars. It is against that backdrop that our Fiscal Year 2021 Budget was developed, with emphasis on sustaining the ground we have gained.

Fiscal Year 2021 Budget Request

The President's Fiscal Year 2021 Budget requests \$243.3 billion for VA—\$109.5 billion in discretionary funding (including medical care collections). The discretionary request is an increase of \$12.9 billion, or 14.1 percent, over the enacted Fiscal Year 2020 appropriation. It would sustain the progress we have made; provide additional resources to improve patient access and timeliness of medical care services for the approximately 9 million Veterans enrolled for VA health care; and improve benefits delivery for our Veterans and their beneficiaries. The President's Fiscal Year 2021 Budget also requests \$133.8 billion in mandatory funding, \$9.1 billion or 7.2 percent above 2020.

For the Fiscal Year 2022 AA, the budget requests \$98.9 billion in discretionary funding including medical care collections for Medical Care and \$145.3 billion in

mandatory advance appropriations for VBA's benefits programs: Compensation and Pensions; Readjustment Benefits; and Veterans Insurance and Indemnities.

For Medical Care, VA is requesting \$94.5 billion (including \$4.5 billion in medical care collections) in Fiscal Year 2021, a 13 percent increase over the 2020 level (including the \$615 million transfer from the Veterans Choice Fund), and a \$2.3 billion increase over the 2021 AA. The request fully supports sustainment of the provisions included in VA MISSION Act, including the streamlining and enhancement of community care services, an urgent care benefit, expansion of our caregiver support program, and other authorities and programs that will improve VA's ability to provide high-quality, timely, Veteran-centric care in line with Veterans' preferences and clinical needs.

This is the largest budget request in VA history, allowing VA to sustain our remarkable progress, continue the upward trajectory of modernizing our systems, and be a center of innovation, providing options to Veterans when it comes to their own care. I urge Congress to support and fully fund our Fiscal Year 2021 and Fiscal Year 2022 AA budget requests.

Next, I will highlight progress we have made, as well as planned activities, in health care, benefits, business transformation, infrastructure, and cemetery operations among others and how the resources we are requesting will contribute to our continued success.

Health Care

VA Medical Centers

In January 2019, VHA began an initiative to optimize clinic practice management and improve access to care through the Improving Capacity, Efficiency, and Productivity initiative. The goal of the initiative was to leverage existing resources and increase internal capacity to maximize the care we provide inside VA with the enhanced eligibility for community care under the VA MISSION Act. The project consisted of a 3-phased approach: Phase 1 focused on improving data accuracy (of labor mapping, bookable time, Primary Care Management Model, stop codes, and person class) through one-on-one support via virtual site visits; Phase 2 centered on implementation of tailored strong practice solutions (based on process measure data) to help medical centers maximize capacity using existing resources; and Phase 3 encouraged VAMCs to leverage innovative methods of care, such as clinical resource hubs, clinical contact centers, e-consults, and telehealth services.

Through this effort, the number of VAMCs that met the VA MISSION Act average wait time standard of less than or equal to 20 days jumped from 47 percent to 65 percent. To replicate this success, we are adopting these same practices at an additional 30 VAMCs.

Over the last several years, we have also increased provider staffing levels significantly. In the last year alone, we increased physician staffing levels by 2 percent; Nurse Practitioners by 7 percent; and Physician Assistants by 3 percent. We also increased clinic support staff for providers and delivered an additional 2.8 million total clinical episodes of care in Fiscal Year 2019. In Fiscal Year 2019, physician workload increased by 2 percent with over 72 million physician encounters. Clinical workload of physicians, measured in a common relative value unit scale that considers the time and intensity of the service, increased by 4 percent. Provider productivity remained relatively constant.

Community Care Network

We continue our successful deployment of the Community Care Network contracts, which use third party administrators (Optum Public Sector Solutions in Regions 1, 2, and 3; TriWest Healthcare Alliance in Region 4; contracts for Regions 5 and 6 are still in progress) to provide a credentialed network of providers for community care. Region 1 is fully deployed; Regions 2 and 3 are in progress; and Region 4 deployment will begin later this year. Our robust network of over 880,000 providers across the United States gives us exceptional flexibility in meeting Veterans' health care needs no matter where they reside. Realizing that we needed to do a better job of paying claims from community providers, our contracts require administrators to process and pay claims from the community providers based on the more stringent timelines included in the VA MISSION Act. The Fiscal Year 2021 Budget requests \$18.5 billion for Community Care, an increase of 21 percent over the Fiscal Year 2020 funding level. These resources will allow us to provide real choice to our Veterans, and we estimate we will have 33 million visits to community care providers in Fiscal Year 2021, an increase of 3.9 percent over Fiscal Year 2020.

Caregiver Support Program

As we implement the VA MISSION Act, we are expanding our caregiver program to family caregivers of eligible Veterans from all eras. Under the law, expansion will begin when VA certifies to Congress that VA has fully implemented a required information technology (IT) system. The expansion will occur in two phases beginning with eligible family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975, with further expansion beginning two years after that. The 2021 Budget request for the Caregivers Support Program (CSP) is \$1.2 billion, \$650 million of which is specifically to implement the program's expansion. In October 2019, VA successfully launched a replacement IT solution, known as the Caregiver Record Management Application (CARMA), to support the program. Our efforts in Fiscal Year 2020 are focused on automating stipend payments and improving existing functionality. Over the course of the next year, we will implement interprofessional Centralized Eligibility and Appeals Teams. This is intended to improve consistency in Program of Comprehensive Assistance for Family Caregivers (PCAFC) eligibility determinations across the enterprise. Led by physicians, these teams will assist with evaluating PCAFC eligibility, tier changes, revocations, and appeals. To ensure smooth operations following PCAFC expansion, VA is working aggressively to recruit, hire and train new team members. These interprofessional teams will be phased in over the course of the next several months and VA anticipates them being fully mission capable in summer 2020.

Some additional key initiatives include the hiring of a program Lead Coordinator at every Veterans Integrated Service Network (VISN) to standardize care and services. We also implemented the Annie Text system to alleviate caregiver stress and burden through supportive text and developed a toolkit for caregivers that educates and provides resources for caregivers on how to recognize and respond to suicide warning signs. CSP continues to develop, implement, and refine services including peer support, caregiver self-care, and dementia care as well as modernizing processes, programming, and staffing to better serve our Nation's Veterans and their caregivers. As of February 2020, over 350 new staff have been added to the program with the goal of hiring approximately 680 more staff in Fiscal Year 2020. To continue to support the expansion for this program under the VA MISSION Act, ongoing workload modeling will be assessed, and additional staff may be required.

Suicide Prevention and Treatment

On March 5, 2019, President Trump signed the *National Roadmap to Empower Veterans and End Suicide* (EO 13861), also known as PREVENTS. This created a Veteran Wellness, Empowerment, and Suicide Prevention Task Force that is tasked with developing, within 1 year, a road map to empower Veterans to pursue an improved quality of life, prevent suicide, prioritize related research activities, and strengthen collaboration across the public and private sectors. This is an all-hands-on-deck approach to empower Veteran well-being with the goal of ending Veteran suicide. The road map is on track to be delivered to the White House in the coming weeks. The PREVENTS Office will then work with government agencies on the Task Force, private-sector entities, and State and local communities to implement the recommendations. The Fiscal Year 2019 Suicide Prevention and Treatment budget was fully executed as planned, supporting the Veterans Crisis Line as well as other critical clinical and community suicide prevention efforts. The Fiscal Year 2021 Budget requests \$10.2 billion for mental health services, a \$683 million increase over Fiscal Year 2020. The Budget specifically would invest \$313 million for suicide prevention programming, a \$76 million increase over the Fiscal Year 2020 enacted level. The request would fund over 19.7 million mental health outpatient visits in a mental health setting, an increase of nearly 272,000 visits over the Fiscal Year 2020 estimate. This builds on VA's current efforts. Since June 2017, VHA has hired 6,047 mental health providers, which is a net increase of 1,754 providers serving our Veterans. Suicide is a national public health issue that affects all Americans. Suicide prevention is my top clinical priority and we are actively implementing a comprehensive public health approach to reach all Veterans—including those who do not receive VA benefits or health services.

Opioid Safety & Reduction Efforts and Treatment of Opioid Use Disorder

The Fiscal Year 2021 Budget includes \$504 million, a \$79.1 million increase over Fiscal Year 2020, to address treatment of OUD and opioid safety and reduction efforts, including specific funding related to programs supported through the Comprehensive Addiction and Recovery Act (CARA) of 2016, Public Law 114–198. Funding for CARA programs is included in the Fiscal Year 2021 Budget at the level of \$121 million, a \$64.6 million requested increase over advanced appropriation previously approved for Fiscal Year 2021 to specifically address over-reliance on opioid analgesics for pain management, improve access to treatment for OUD, and to pro-

vide safe and effective use of opioid therapy when clinically indicated. This CARA budget would provide support for deployment of evidence-based practices, toolkits, and research to enhance and expand patient-centered, safe, and effective pain care. This will be accomplished through several efforts including: developing and implementing a national program for Opioid Stewardship that will enhance the continued expansion and implementation of the Opioid Safety Initiative; providing funding for fully staffing and supporting CARA-required Pain Management Teams with hiring, toolkits, training and expert guidance; and providing increased access to interdisciplinary pain management through multiple modalities including but not limited to: increased field staffing for pain management teams at facilities; greatly expanded access to telehealth for pain management; and treatment of OUD so that we can reach all Veterans under our care. Another particularly important risk mitigation strategy for opioids, and for all controlled substance, is access to State Prescription Drug Monitoring Programs (PDMP), which allow for safer prescribing. VA is working toward an automated process of PDMP queries that can be accessed within EHR by prescribers and their delegates and therefore integrates into the clinical workflow. We expect this to be implemented in FY 2020. VA is in the process of integrating PDMPs into both the legacy health records system and the new EHR. PDMP's solution for the legacy system will provide integrated access for clinicians and delegates across the available State data bases and the Military Health System. VA's new EHR will initially provide integrated access to prescribers directly to the Washington State PDMP.

Multiple initiatives are underway to increase access to life-saving medication for OUD. In the past 4 years, the number of Veterans with OUD receiving buprenorphine, injectable naltrexone, or opioid treatment program administered methadone increased by more than 20 percent. Most of these medications are provided in substance use disorder treatment clinics, but only about half of Veterans clinically diagnosed with OUD receive treatment in these clinics. In order to reach Veterans where they are, VA launched the Stepped Care for Opioid Use Disorder Train-the-Trainer initiative to increase access to OUD medication treatment in Primary Care, General Mental Health, and Pain Management Clinics. In the first 14 months, 18 pilot teams increased the number of patients receiving buprenorphine in these clinics by 141 percent. During FY 2020, VA plans to provide additional training and support to expand access to stepped care for OUD treatment in settings outside of substance use disorder specialty care with future plans focused on ensuring timely access to life saving medication for the treatment of OUD regardless of where the Veteran presents for care.

VA's Opioid Safety Initiative has greatly reduced reliance on opioid medication for pain management, in part by reducing opioid prescribing by more than 55 percent over the past 5 years. Seventy-five percent of VA's reduction can be attributed to not starting Veterans with chronic, non-cancer pain on long-term opioid therapy and instead utilizing multimodal strategies that manage Veteran pain more effectively long-term. As VA continues its efforts to address opioid over-use, options such as non-opioid medications; behavioral therapy; restorative therapies (such as physical therapy and occupational therapy); interventional pain care; and the Whole Health (WH) system of care transformation that includes complementary and integrative health (CIH) treatments (such as massage therapy, yoga, meditation, acupuncture, Tai Chi, etc.) are important components to VA's Pain Management Strategy. Initial results from the analysis of the 18 WH Flagship sites as required by CARA have just become available and demonstrate a threefold reduction in opioid use among Veterans with chronic pain who used WH services (including CIH) compared to those who did not in the first 2 years. Monitoring will continue of these original 18 sites as well as the 36 additional facilities that were added in 2018. As required by CARA, all VHA facilities have established or are in the process of implementing interdisciplinary pain management teams or pain clinics that support Veterans and our Primary Care Teams in delivering the best pain care possible. While these efforts are well underway, we must continue to provide access to these safe and effective pain care approaches systemwide, wherever the Veteran is located.

Women Veterans

The number of women Veterans enrolling in VA health care is increasing, placing new demands on VA's health care system. Women make up 16.9 percent of today's Active Duty military forces and 19 percent of National Guard and Reserves. More women are choosing VA for their health care than ever before, with women accounting for over 30 percent of the increase in Veterans served over the past 5 years. The number of women Veterans using VHA services has tripled since 2001, growing from 159,810 to over 500,000 today. To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and

access for women Veterans by investing \$50 million in a hiring initiative in 2021. The Fiscal Year 2021 Budget projects \$626 million for gender-specific women Veterans' health care, a \$53 million increase over Fiscal Year 2020. This Budget would also continue to support a full-time Women Veterans Program Manager at every VA health care system. VHA has also made a commitment to train mental health providers to address women Veterans' complex and unique needs, including gender-related suicide risks. One of our key initiatives is the Women's Mental Health Mini-Residency and national Reproductive Mental Health/Psychiatry consultation initiatives. To date, more than 450 VA providers have attended the mini-residency. Participants indicate that the training increased their competency to provide gender-sensitive care to women Veterans and positively impacted women's mental health services at their local facility. The mini-residency is required training for all Women's Mental Health Champions, who serve as a local contact for women Veterans' mental health.

Additionally, VA launched a National Women's Reproductive Mental Health Consultation Program in Fiscal Year 2020. With this new resource, expert consultation is now available to all VA clinicians on topics such as treating premenstrual, perinatal, and perimenopausal mood disorders, and treating women's mental health conditions that can be affected by gynecologic conditions. Without this program, key mental health care needs of women might not be detected or treated. User feedback has been overwhelmingly positive. Consultations have focused on highly complex patient presentations and prescribing considerations and reaffirm the critical need for this national resource.

This Budget would continue to support Women's Mental Health training and consultation programs. It would also support 0.10 Full-Time Equivalent (FTE) protected time for a Women's Mental Health Champion at every VHA health care system to facilitate consultations and develop resources that increase the visibility and accessibility of gender-sensitive women's mental health care and contribute to a welcoming care environment.

Treatment of Military Sexual Trauma

When asked by their VA health care provider, about 1 in 3 women and 1 in 100 men report that they experienced sexual assault or sexual harassment during their military service. These experiences, which VA refers to as military sexual trauma (MST), can have a significant impact on Veterans' mental health, physical health, general well-being, and are also associated with an increased risk for suicide. VA's services for MST can be critical resources to help Veterans in their recovery journey. Since VHA began systematic MST-related monitoring in Fiscal Year 2007, there has been a 344 percent increase in the number of female Veterans receiving MST-related outpatient care and a 256 percent increase in the number of male Veterans receiving MST-related outpatient care. In Fiscal Year 2019, more than 2,014,671 MST-related outpatient visits were provided—an 11 percent increase from Fiscal Year 2018. The cost of providing MST-related care is incorporated into broader health care costs for each VA health care system (HCS) and, as such, VHA's requested increases for health care services funding more broadly will directly benefit MST survivors. These funds are needed to maintain the full continuum of outpatient, inpatient, and residential mental health services as well as medical care services that are crucial to assisting MST survivors in their recovery. Funding also supports VHA's universal screening program in which every Veteran seen for health care is asked about experiences of MST, so that he or she can be connected with MST-related services as appropriate. Additionally, funding supports the MST Coordinator program, in which every VA health care system has a designated MST Coordinator who can help Veterans access MST-related services and programs.

Precision Oncology

The Fiscal Year 2021 Budget includes \$75 million to support VHA's precision oncology initiative, which aims to improve the lives of Veterans with cancer by ensuring that no matter where they live, they have access to cutting-edge cancer therapy using Precision Medicine, telehealth, and a learning HCS that integrates research with clinical care. Precision oncology is an evolution from one-size-fits-all cancer care. We are learning that we can increase treatment success and decrease side-effects by picking the treatment based upon characteristics of the patient and of the cancer. It primarily focuses on mutations in the patient's and cancer's DNA, respectively. The requested Fiscal Year 2021 funding for this initiative would support:

- Investment in new national lung cancer network and expanded prostate cancer coverage;

- Enhanced ability to track – and conduct performance improvement – across a broader range of precision oncology quality measures at the national level;
- Scaling access to genetic counseling with the growth of genetic testing;
- Expanding access to national tele-oncology;
- Additional clinical trials for prostate and lung cancer; and
- Exploration of new opportunities for breast cancer research.

Telehealth

The Fiscal Year 2021 Budget request includes \$1.3 billion for care provided through telehealth. VA leverages telehealth technologies to enhance the accessibility, capacity, and quality of VA health care for Veterans, their families, and their caregivers anywhere in the country. VA achieved more than 1.3 million video telehealth visits in Fiscal Year 2019, a 26 percent increase in video telehealth visits over the prior year. Representing the fastest growing segment of VA telehealth, more than 10 percent of the 900,000 Veterans using VA telehealth received care through video telehealth in the comfort of their home or another non-VA location using VA Video Connect. In Fiscal Year 2021, our goal is to have all VA providers offering VA Video Connect services to Veterans when clinically appropriate and requested by the Veteran.

Strengthening VA's Internal System of Care

The Fiscal Year 2021 Budget supports VHA's Plan for Modernization including continued progress toward becoming a high reliability organization (HRO) and the realignment of VHA Central Office (VHACO) to better support our care providers in the field. The HRO model is the managerial framework for transformational change. HROs focus on continuous improvement and enhancing the customer experience. VHA has identified its own path to high reliability to meet Veterans' unique needs. Starting in 2019, VHA began instilling HRO principles, tools, and techniques at every level of the organization to address root causes; advance VA and VHA priorities; and ultimately achieve our vision of providing exceptional, coordinated, and connected care for Veteran health and well-being. In Fiscal Year 2021, VHA will continue to promote HRO principles and move closer to its aim of becoming a "zero harm" organization that is constantly learning and applying those lessons toward improving Veteran care. On January 8, 2020, VA announced the redesign of VHACO as part of its modernization efforts to reflect leading health care industry practices and address clinical integration. The new structure now supports joint leadership roles of a chief medical officer and expanded chief nursing officer. The new structure clarifies office roles and streamlines responsibilities to eliminate fragmentation, overlap, and duplication. It also allows VHA to be more agile and to respond to changes and make decisions more quickly. This positions VHA to better support Veterans Integrated Service Networks (VISN) and facilities directly serving Veterans. VHACO staff includes the approximately 20,000 staff located throughout the country that provide operational support to VAMCs. The proposed change in structure will not result in a reduction or termination of staff.

Animal Research

VA conducts an array of research in areas significant to Veterans' health care. VA only conducts research with animals when absolutely necessary. There are some research questions that cannot be addressed other than by research with animals, and VA refuses to ignore Veterans whose health care needs that research. For example, animal research in Cleveland involving researchers from VA recently led to the development of a device that allows Veterans with spinal cord injuries to cough on their own and communicate with a stronger voice, leading to increased independence and a significant reduction in respiratory infections and deaths. This important advancement would not have been possible using computer simulations, test tube techniques, 'organ on a chip' technology, or smaller animal species. VA has very few animal studies active at any one time, but some health care problems like this one can only be addressed with animal research, underscoring the importance of this kind of research in helping Veterans who have been severely injured on the battlefield.

Benefits

Blue Water Navy

One of the most significant changes for our Veterans in 2019, was the signing of the *Blue Water Navy Vietnam Veterans Act of 2019* in June, with an effective date of January 1, 2020. As of February 20, 2020, VA has received over 36,000 potential

Blue Water Navy (BWN) claims and has already issued \$105 million in retroactive benefit payments to more than 3,000 BWN Veterans and survivors. In Fiscal Year 2021, VA expects to receive 70,000 BWN claims and appeals. VA's Fiscal Year 2021 funding request includes \$137 million for VBA General Operating Expenses (GOE) to support BWN implementation. This Budget request includes sustaining 691 FTE for claims processing; call center agents; quality reviews; and contracting for the continued scanning of deck logs, service records, and paper claims from the National Archives and Records Administration. The Budget also supports standard business operations, which include support to enable Private Medical Records requests, audit reviews of deck log transcription services, and strategic communications/outreach to Veterans and key stakeholders.

Forever GI Bill

The Fiscal Year 2021 Budget for VBA includes an increase of \$20.5 million as a result of provisions in The Harry W. Colmery Veterans Educational Assistance Act (the Colmery Act) of 2017. The Department remains steadfast in its commitment to ensuring every Post-9/11 GI Bill beneficiary is made whole based on the rates established under the Colmery Act. We have taken significant steps to ensure there is broad awareness and understanding of our actions to date. VA executed a comprehensive communications and training campaign to schools, Veteran Service Organizations, State approving agencies, students, beneficiaries, and other stakeholders to regularly provide updates and seek input on VA activities and progress.

Appeals Modernization

One year after the successful implementation of the Veterans Appeals Improvement and Modernization Act (AMA), VA is encouraged by an active business transformation that is improving Veterans' appeals experience. AMA is transforming VA's complex and lengthy appeals process into one that is simple, timely, and fair to Veterans and that ultimately gives Veterans choice, control, and clarity in the claims and appeals processes. The Fiscal Year 2021 request of \$198.0 million for the Board of Veterans' Appeals (the Board) is \$24 million above the Fiscal Year 2020 enacted budget and will sustain approximately 1,161 FTE. This Budget would prioritize the resolution of legacy appeals at the Board while simultaneously adjudicating appeals under AMA. In addition to adjudicating appeals and claims under AMA, addressing pending legacy appeals will continue to be a priority for VA in Fiscal Year 2020 and Fiscal Year 2021. In October, VA finalized an enterprise plan to resolve non-remand legacy appeals by the end of calendar year 2022. I am proud of the work being done at VA to make sure those Veterans waiting the longest for a decision get their results.

Business Transformation

Business transformation continues to be central to my focus and is essential for the Department to move beyond compartmentalization of the past and empower our employees serving Veterans in the field to provide world-class customer service. This means reforming the systems responsible for claims and appeals, GI Bill benefits, human resources, financial and acquisition management, supply chain management, and construction.

Electronic Health Record Modernization

In 2018, VA awarded Cerner Government Services, Inc. a 10-year contract to acquire the same EHR solution being deployed by DoD, which will enable seamless sharing of health information, improve care delivery and coordination, and provide clinicians with data and tools that support patient safety. With the support of Congress, VA's Office of Electronic Health Record Modernization has made significant strides toward Go-Live at our initial operating capability sites in the Pacific Northwest.

The 2021 Budget includes \$2.6 billion to continue VA's efforts to implement a longitudinal health record and to ensure interoperability with DoD. This request provides necessary resources for full deployment of VA's new EHR solution at the remaining sites in VISN 20 and VISN 22. Additionally, it partially funds the concurrent deployment of waves comprised of sites in VISNs 7 and 21. VA's new EHR solution will be deployed at VAMCs, as well as associated clinics, Vet Centers, mobile units, and ancillary facilities.

Information Technology Modernization

The 2021 Budget of \$4.9 billion continues to invest in the Office of Information and Technology (OIT) modernization effort, enabling us to streamline VA efforts to

operate more effectively and decrease our spending while increasing the services we provide. OIT delivers the necessary technology and expertise that supports Veterans and their families through effective communication and management of people, technology, business requirements, and financial processes.

The requested \$496 million in technology development funding will be dedicated to specific modernization efforts to support major initiatives such as the VA MIS-SION Act, the Colmery Act, BWN, LogiCole (formerly DMLSS), and the Financial Management Business Transformation (FMBT). The Budget also invests \$341 million for information security to protect Veterans' and employees' information.

The 2021 OIT Budget includes \$250 million for the Infrastructure Readiness Program (IRP) to guide the ongoing refresh and replacement of the IT Infrastructure resources that sustain all VA IT operations. IRP identifies the current State of the IT Infrastructure and provides analysis for the strategy to refresh and modernize IT Infrastructure assets based on equipment age, expiration of warranty, support limitations, lifecycle estimates, business requirements, technology roadmap, financial planning and policy changes. The term "Technical Debt" is normally associated with software development and is generally understood to relate to making short term decisions and tradeoffs that can cause significant rework to address in the long term. For IRP purposes, "technical debt" refers to the cost needed to bring legacy infrastructure components to a State of full efficacy. Technical debt multiplies year over year and reduces available resources for allocation to VA business priorities.

Reducing technical debt will enable VA to more rapidly deliver IT solutions for joint VA business priorities that enable the exceptional customer experience, care, benefits, and services Veterans have earned. A robust, healthy IT infrastructure is necessary to ensure delivery of reliable, available, and responsive IT services to all VA staff offices and administration customers as well as Veterans.

Financial Management Business Transformation

VA's financial management system for essential accounting and financial activities is more than 30 years old and is growing more obsolete by the day. VA established the FMBT program to achieve VA's goal of modernizing its financial and acquisition management systems. In support of the FMBT program, the 2021 Budget requests a total of \$221 million for FMBT, including \$111.1 million in IT funds and General Administration funding of \$13.9 million. FMBT will leverage the Franchise Fund to bill costs to the Administrations and Staff Offices when the Franchise Fund sells non-IT services to these customers. Additionally, FMBT is leveraging the Supply Fund for costs associated with implementing the acquisition community. FMBT will achieve its first scheduled deployment in July 2020 with the implementation of the National Cemetery Administration (NCA). This will be followed by the implementation of Veterans Benefits Administration (VBA) General Operating Expense (GOE) in February 2021.

Supply Chain Modernization and LogiCole

VA's request includes \$111.5 million for transitioning VA's Supply Chain Management. VA is embarking on a supply chain transformation program designed to build a lean, efficient supply chain that provides timely access to meaningful data focused on patient and financial outcomes.

VA is pursuing a holistic modernization effort which will address people, training, processes, data, and automated systems. To achieve greater efficiencies by partnering with other Government agencies, VA will strengthen its long-standing relationships with DoD by leveraging expertise to modernize VA's supply chain operations, while allowing VA to remain fully committed to providing quality health care and applying resources where they are most needed.

Based on the collaboration with DoD, VA will transition to LogiCole, formerly DMLSS, on an enterprise-wide basis to replace VA's existing logistics and supply chain solution. VA's current system faces numerous challenges and is not equipped to address the complexity of decisionmaking and integration required across functions, such as acquisition, logistics, and construction. The LogiCole solution will ensure that the right products are delivered to the right places at the right time, while providing the best value to the government and taxpayers.

VA is piloting LogiCole at James A. Lovell Federal Health Care Center and VA initial EHR sites in Spokane and Seattle to analyze VA enterprise-wide application. In LogiCole, VA is leveraging a proven system that DoD has developed, tested, and implemented.

Infrastructure Improvements and Streamlining

In Fiscal Year 2021, VA will continue improving its infrastructure and provide for expansion of health care, burial, and benefits services where needed most. The re-

quest includes \$1.4 billion in Major Construction funding, as well as \$400 million in Minor Construction to fund VA's highest priority infrastructure projects. These funding levels are consistent with our requests in recent years and represent a combined 8.5 percent increase for Major Construction and Minor Construction funding over the FY 2020 appropriation.

Major and Minor Construction

This funding supports major medical facility projects including providing the final funding required to complete projects in Tacoma, WA – American Lake Construction of New Specialty Care Building 201, and Long Beach, CA – Mental Health and Community Living Center. The request also includes continued funding for ongoing major medical projects at Canandaigua, NY – Construction and Renovation; Alameda, CA – Community Based Outpatient Clinic & National Cemetery; San Diego, CA – Spinal Cord Injury and Seismic Corrections; Livermore, CA – Realignment and Closure of the Livermore Campus; and Dallas, TX – Spinal Cord Injury Center. The request also includes funding to construct an inpatient facility in Tulsa, OK, which will be VA's second project under the authorities provided in the Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016, also referred to as CHIP IN. The potential project will include both VA's contribution and resources from a partner who will construct a health care facility for Veterans to be donated to VA upon completion.

The Fiscal Year 2021 request includes funding for national cemetery expansion and improvement projects in San Antonio, TX, and San Diego, CA. The Fiscal Year 2021 Budget provides funds for the continued support of major construction program including the seismic initiative that was implemented in 2019 to address VA's highest priority facilities in need of seismic repairs and upgrades.

The request also includes \$400 million in minor construction funds that will be used to expand health care, burial, and benefits services for Veterans. The minor construction request includes funding for 37 newly identified projects as well as existing partially funded projects.

Leasing

VA is also requesting authorization of 13 major medical leases in 2021 to ensure access to health care is available in those areas. The 2021 request includes major medical facility leases that VA previously submitted for congressional authorization in Fiscal Year 2019 and Fiscal Year 2020. These leases include new leases totaling \$88 million and 371,051 net usable square feet (NUSF) in Columbia, MO; Hampton, VA; Lawrence, IN; and Salt Lake City, UT; and replacement leases totaling \$187 million and 849,428 NUSF in Atlanta, GA; Baltimore, MD; Baton Rouge, LA; Beaufort, SC; Beaumont, TX; Jacksonville, NC; Nashville, TN; Plano, TX, and Prince George's County, MD. VA is requesting funding of \$1.054 billion to support ongoing leases and delivery of additional leased facilities during the year. These new and ongoing leases represent over 1.2 million square feet of leased space providing state-of-the-art care for our Nation's Veterans.

Repurposing or Disposing Vacant Facilities

To maximize resources for Veterans, VA repurposed or disposed of 189 of the 430 vacant or mostly vacant buildings since June 2017 resulting in an estimated \$4.5 million in annual operations and maintenance cost avoidance. Due diligence efforts (environmental/historic) for the remaining buildings are substantially complete, allowing them to proceed through the final disposal or reuse process. VA continues to identify additional vacant buildings for disposal or reuse in order to continue to maximize resources and save taxpayer dollars.

Customer Service

As I have described in past testimony, my prime directive is customer service. In order to sustain VA's commitment to customer experience I will be requesting in Fiscal Year 2021 a shift from a reimbursable authority (RA) funding model to a hybrid RA and budget authority (BA) model for our Veterans Experience Office (VEO). The Fiscal Year 2021 request is for \$11.5 million in direct BA funding. This strategic shift in VEO's budget model will highlight your commitment and VA's commitment to customer service and the institutionalization of customer experience capabilities within the Department now and in the future. Veterans, their families, caregivers, and survivors deserve nothing less than to know that VA is prioritizing their experiences as a core part of the business. The results and impact of VEO are showing. Veteran trust in VA has increased by 12 percent since 2016. In the last year, Veteran satisfaction with the redesigned VA.gov Website has increased by 9 percent

using Veteran feedback to improve the site – proof positive that when the Department employs VEO capabilities and practices, it produces better results for Veterans, their families, caregivers, and survivors. VEO is also driving the personalization aspect of customer experience by leveraging business processes and integrated technology solutions for Veterans and their families to make their online and telephonic interactions with VA easier and on par with industry. From their first interaction with VA, customers are “known” because of an integrated VA Profile, a data management initiative that synchronizes Veteran data across the VA’s systems, thereby creating a comprehensive Veteran customer profile. An accurate customer profile synchronized across multiple systems is significant, as more than a half million Veterans update their contact information with VA each month; now, they do not have to provide the same information each time they contact VA and VA employees can better focus their time on serving Veterans’ needs. VA Profile has already made more than 5.7 million contact information updates.

National Cemetery Administration

The President’s Fiscal Year 2021 Budget positions NCA to meet Veterans’ emerging burial and memorial needs through the continued implementation of its key priorities: Preserving the Legacy: Ensuring “No Veteran Ever Dies”; Providing Access and Choosing VA; and Partnering to Serve Veterans. The 2021 Budget includes \$360 million for NCA’s operations and maintenance account, an increase of \$32 million (9.8 percent) over the Fiscal Year 2020 level. This request will fund the 2,085 FTE employees needed to meet NCA’s increasing workload and expansion of services, while maintaining our reputation as a world-class service provider. In 2019, NCA achieved an American Customer Satisfaction Index score of 97, the highest result ever achieved for any organization in either the public or private sector. This ranking is the seventh consecutive time NCA received the top rating among participating organizations. The 2021 Budget will allow us to build upon this unprecedented record of success.

In Fiscal Year 2021, NCA will inter an estimated 137,600 Veterans and eligible family members and care for over 4 million gravesites at 156 National Cemeteries, which includes 11 cemeteries being transferred from the Department of the Army, and 33 soldiers’ lots and monument sites. NCA will continue to memorialize Veterans by providing an estimated 360,000 headstones/markers and distributing 630,600 Presidential Memorial Certificates. NCA will also continue efforts to modernize Veterans’ memorialization through the Veterans Legacy Program and Veterans Legacy Memorial (VLM). In 2021, NCA will again partner with universities and communities to tell the stories of Veterans buried in VA national cemeteries. In addition to these partnerships, NCA will continue the roll out of VLM, a public memorial platform that shares Veteran-related content with the general public.

VA is committed to investing in NCA’s infrastructure, particularly to keep existing National Cemeteries open and to construct new cemeteries consistent with existing burial policies. NCA is amid the largest expansion of the cemetery system since the Civil War. NCA will establish 18 new national cemeteries across the country, including rural and urban locations. The 2021 Budget includes operations and maintenance funding to continue activation of new cemeteries that are open for burials. The Fiscal Year 2021 request also includes \$94 million in major construction funds for two gravesite expansion projects (Fort Sam Houston in San Antonio, TX and Miramar, CA) and \$86 million in minor construction funds for gravesite expansion and columbaria projects to keep existing national cemeteries open, address infrastructure deficiencies and other requirements necessary to support national cemetery operations.

The Budget request also includes \$45 million for the Veteran Cemetery Grant Program to continue important partnerships with States and tribal organizations. Upon completion of these expansion projects, and the opening of new national, State and tribal cemeteries, nearly 95 percent of the total Veteran population—about 20 million Veterans—will have access to a burial option in a national or grant-funded Veterans cemetery within 75 miles of their homes.

Accountability

The total request for the Office of Accountability and Whistleblower Protection (OAWP) in Fiscal Year 2021 is \$26.5 million, which includes funding for 125 FTE employees. This is an additional \$4.3 million, or 18 percent over the Fiscal Year 2020 appropriation and includes funding for an additional 11 FTEs. This funding level will enable OAWP to implement the oversight and compliance requirements of the VA Accountability and Whistleblower Protection Act of 2017 and continue to conduct thorough and timely investigations into whistleblower disclosures, allega-

tions of senior leader misconduct and poor performance, and whistleblower retaliation. In Fiscal Year 2019, OAWP received 2,951 submissions, directly conducted approximately 167 investigations, and monitored approximately 551 investigations that were referred out for investigation to VA Administrations and staff offices, as required by law. These efforts are part of VA's effort to build public trust and confidence in the entire VA system and are critical to our transformation.

The Fiscal Year 2021 Budget also requests \$228 million for the Office of the Inspector General (OIG), an \$18 million increase over the 2020 enacted level, for 1,048 FTEs in 2021 to support essential oversight of VA's programs and operations through independent audits, inspections, reviews, and investigations; and for the timely detection and deterrence of fraud, waste, and abuse. Additional resources will be used to enhance oversight in program areas that are vital to Veterans and taxpayers, particularly implementation of the VA MISSION Act and the ongoing EHR modernization effort. To that end, OIG will significantly expand oversight of community care, including ongoing efforts to detect and deter health care fraud, financial stewardship, and procurement.

Conclusion

Thank you for the opportunity to appear before you today to address our Fiscal Year 2021 Budget and Fiscal Year 2022 AA Budget request. The resources requested in this budget will ensure VA remains on track to meet congressional intent to implement the VA MISSION Act and continue to optimize care within VHA.

Mr. Chairman, I look forward to working with you and this Committee. I am eager to continue building on the successes we have had so far and to continue to fulfill the President's promise to provide care to Veterans when and where they need it. There is significant work ahead of us and we look forward to building on our reform agenda and delivering an integrated VA that is agile, adaptive, and delivers on our promises to America's Veterans.

Prepared Statement of Adrian Atizado

Chairman Takano, Ranking Member Roe, and members of the committee, the co-authors of *The Independent Budget (IB)*—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW)—are pleased to present our views regarding the President's Fiscal Year (FY) 2021 funding request for the Department of Veterans Affairs (VA), including advance appropriations for Fiscal Year 2022.

Prior to the Administration's budget request, the *IB* released its comprehensive VA budget recommendations for all discretionary programs for Fiscal Year 2021, as well as advance appropriations recommendations for medical care accounts for Fiscal Year 2022.¹ The recommendations also include funding to implement the VA MISSION Act of 2018, Public Law (P.L.) 115–182, and other reform efforts. The *IB* urges Congress to continue vigorous oversight of VA to ensure an accurate assessment of its true needs. Our own Fiscal Year 2021 estimates affirm that these needs continue to grow.

For Fiscal Year 2021, the *IB* recommends \$114.8 billion in total discretionary budget authority for the VA. This recommendation is \$4.4 billion more than the Administration's request and an 18 percent increase over Fiscal Year 2020. After reviewing the Administration's budget request for VA, which provides a 13 percent increase, we believe the request falls short of meeting the needs of America's veterans in light of the requirements of the VA MISSION Act, increasing need for medical care, claims and appeals processing, information technology (IT) modernization and construction needs.

The Administration's Fiscal Year 2021 request for all VA medical care of approximately \$95.6 billion is \$2.8 billion less than the *IB* estimates is necessary to fully meet the demand by veterans for health care during the fiscal year. For Fiscal Year 2021, the *IB* recommends approximately \$98.4 billion in total medical care funding and approximately \$100.6 billion for Fiscal Year 2022. This recommendation reflects the necessary adjustments to the baseline for all Medical Care program funding of the preceding fiscal year, increases based on new and existing workload, and the 3.1 percent Federal pay adjustment, among other things. Our recommendation did not assume any funds remaining in the Veterans Choice Fund established by section 802 of P.L. 113–146, the Veterans Access, Choice, and Accountability Act of 2014

¹The full *IB* budget report addressing all aspects of discretionary funding for VA can be downloaded at www.independentbudget.org.

(VACAA) based on P.L. 116–94, the Further Consolidated Appropriations Act, 2020, and subsequent appropriations for the section 802 account.

Medical Services.—For Fiscal Year 2021, the *IB* recommends \$64.4 billion for VA Medical Services. This recommendation is a reflection of multiple components including the current services estimate, the increase in patient workload, and additional medical care program costs:

- The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate also assumes a 3.1 percent increase for pay and benefits across the board for all VA employees in Fiscal Year 2021.
- Our estimate of growth in patient workload is based on a projected increase of approximately 65,000 new unique patients. These patients include priority group 1–8 veterans and covered non-veterans, which we estimate the cost to be approximately \$991 million.
- The *IB* believes that there are additional projected medical program funding needs for VA totaling over \$2.1 billion. Specifically, an additional \$328 million to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA’s Prosthetics and Sensory Aids Service); \$200 million to expand and improve services for women veterans; \$20 million to support VA’s authority for reproductive services including in vitro fertilization (IVF); \$779 million to implement eligibility expansion of the VA comprehensive caregiver support program; \$776 million to close the reported vacancies for both outpatient mental health and Patient Aligned Care Team (PACT) by 10 percent.

The Administration’s Fiscal Year 2021 budget request for VA Medical Services, including collections, of \$60.4 billion is approximately \$4.0 billion below the *IB* recommendation. Although the Administration’s request reflects an apparent increase of 10 percent over Fiscal Year 2020 funding levels, the *IB* believes that when taking into account the increased cost to maintain current services and anticipated increases in workload, as well as increased costs inside VA due to the VA MISSION Act, that the requested increase is not enough. Of great concern to our members is the timeline Congress set out in the VA MISSION Act for expanding its comprehensive caregiver support program has clearly not been met. The delay in certifying the IT solution to support expansion of the caregiver program and VA’s failure to timely publish a Notice of Purpose Rulemaking raises troubling concerns about VA’s ability to fully implement the caregiver expansion. Severely injured World War II, Korean War, and Vietnam War veterans and their family caregivers have waited nearly a decade for equal treatment and it is simply unacceptable to ask them to wait longer.

In terms of funding, the Administration’s Fiscal Year 2021 request included approximately \$1.2 billion for VA’s comprehensive caregiver support program. Because this request represents an overall increase of \$485 million over Fiscal Year 2020, it is noteworthy that \$650 million is to implement the eligibility expansion required under the VA MISSION Act; thus, we are concerned this request assumes a reduction in the number of existing program participants—approximately 20,000 approved family caregivers. The *IB* recommends appropriating \$779 million for Fiscal Year 2021 for the phase-one expansion scheduled toward the end of Fiscal Year 2020, with only a small portion of the expansion cost absorbed in Fiscal Year 2020. The *IB*’s recommendation is based on the Congressional Budget Office estimate for preparing the program, including increased staffing and IT needs, and the beginning of the first phase of expansion. To continue the expansion, the *IB* recommends \$1.4 billion for Fiscal Year 2022.

Medical Community Care.—The *IB* recommends \$18.2 billion for this account for Fiscal Year 2021, which includes the growth in current services. We note the volatility in obligations within this account particularly for contractual services, for which the vast majority of obligated funds are spent. In addition, our recommendation does not assume any funds remaining in the Veterans Choice Fund established by section 802 of the VACAA based on P.L. 116–94. For Fiscal Year 2022, the *IB* recommends \$18.7 billion for Medical Community Care.

The Administration’s Fiscal Year 2021 budget authority request for Medical Community Care of \$20.4 billion is comprised of \$3.2 billion increase over Fiscal Year 2020 funding, an estimated increase of \$247 million in medical community care collections from \$537 million to \$784 million, and \$1.1 billion remaining in the Veterans Choice Fund account. We have serious doubts whether projected to actual spending will converge given the volatility in obligations within this account, the transfer of administrative responsibilities for certain regional networks and provider

coverage, and new responsibilities VA is assuming under the new Veterans Community Care Program. Most concerning to the *IB* is VA's proposal to increase non-VA care by nearly 25 percent next Fiscal Year compared to just over a 10 percent funding increase for care provided at VA medical facilities because we believe that veterans prefer to get care from VA providers than through the Veterans Community Care Program.

Medical and Prosthetic Research.—The Administration's request of \$787 million is nearly \$82 million below the *IB* recommendation of \$860 million. The request represents a 2 percent cut, at a time when medical research inflation is increasing in excess of 2 percent. The VA Medical and Prosthetic Research program is widely acknowledged as a success, with direct and significant contributions to improved care for veterans and an elevated standard of care for all Americans. This research program is also an important tool in VA's recruitment and retention of health care professionals and clinician-scientists to serve our Nation's veterans. This reduction would diminish VA's ability to provide the most advanced treatments available to injured and ill veterans in the future, one of VA's core missions.

Vocational Rehabilitation and Employment (VR&E).—This program was authorized to hire an additional 174 FTEs in Fiscal Year 2019 and implemented workforce increases and tech modernization. In order to ensure the 1 to 125 ratio is maintained nationally and even within each VA regional office or region, for Fiscal Year 2021, the *IB* recommends \$17.2 million for 156 FTE for VR&E, 87 percent of which are Vocational Rehabilitation Counselors (VRCs). As recently reported, VRCs can spend 60 percent of their time with administrative functions, thus necessitating the addition of administrative staff.

However, in the recent Administration's budget request, it was indicated that with guidance in the Fiscal Year 2020 Appropriations Act, 2020, VBA will also re-allocate 166 FTE to VR&E, a result of decreased resources required to process legacy appeals, to support anticipated program growth and maintain the 1:125 counselor-to-veteran ratio at the station level. To be clear, the 1:125 ratio is based on VRCs and not administrative staff. The Administration's proposal would not increase the number of VRCs, only administrative staff. While we agree that an increase in administrative staff is warranted, the number of FTE for VRCs needs to be addressed as well.

Board of Veterans' Appeals (BVA).—For Fiscal Year 2021, the *IB* recommends approximately \$218 million for the BVA, an increase of approximately \$36 million over the estimated Fiscal Year 2020 appropriations level, which reflects funding for current services with increases for inflation and Federal pay raises and an additional 100 FTE.

In February 2019, the Veterans Appeals Improvement and Modernization Act (AMA), P.L. 115–55, took full effect, making significant changes in how veterans appeal VBA claims decisions, both within VBA and at the Board of Veterans' Appeals (BVA). There are currently 17,000 pending AMA hearings with the Board and 59,000 pending legacy hearings, for a total of 66,000 pending hearings. In Fiscal Year 2019, BVA conducted a record number of 22,743 hearings, a 38 percent increase over the prior year. Even at that rate, it will take three years to hold all hearings for legacy appeals and yet not address the current 17,000 pending AMA appeals with requested hearings, not to mention the additional AMA appeals received during those three years.

The Administration's budget request would not increase staffing at the Board. It indicates VA expects to lose 29 FTE, based on attrition, in Fiscal Year 2021. However, as the number of backlog hearings has not drastically been reduced and many of the legacy hearings have been pending for years, we are recommending an increase of 100 FTE for the Board to address the 66,000 pending hearings.

Information Technology (IT).—VA relies extensively on information technology to meet day-to-day operational needs. At Congress' direction, over a decade ago, VA centralized all IT budget authority, management, and development under a chief information officer (CIO). It is now one of the few agencies of its size with a CIO that has complete IT authority affecting the entire organization. Centralization mandated fiscal discipline, security, standardization, and interoperability. Yet little oversight, if any, has been conducted of this organization since centralization and its performance in supporting VA's statutory missions, including benefits and health care delivery, research, and education and training of health professions. For Fiscal Year 2021, the IBVSOs recommend approximately \$4.3 billion for the administration of the VA's IT program to meet the need to sustain VistA for an estimated 7–10 years after initial operating capabilities are attained at initial sites for replacing VistA.

For several years, the VA has indicated the development of IT applications remains under VA's three separate administrations—VBA, VHA, and the National Cemetery Administration (NCA); however, the development funding has been in decline over the last 5 years. In nominal dollars since 2014, total development funding has been reduced by over 40 percent while the overall funding has increased by 6 percent. We are pleased VA is requesting an increase of \$68 million in development activities. The *IB* similarly recommends \$150 million, of which \$65 million would be provided to VA's Education Services and the remaining \$85 million to OIT, to develop an IT system capable of handling today's difficult tasks, and tomorrow's upcoming changes. In addition, we recommend IT development funding of \$15 million for Fiscal Year 2021 for the BVA's Case Flow, which currently does not have all the functionalities needed to replace the legacy Veterans Appeals Control and Locator System (VACOLS).

To support the electronic health record modernization efforts in Fiscal Year 2021, the *IB* recommends \$2.48 billion, which includes \$180 million to support accelerated deployment of Cerner Millennium Scheduling System. These amounts are also based on VA's deployment schedule estimating Fiscal Year 2021 resource needs to complete initial operating capability sites and deployment throughout the remainder of VISN 20 and 22, and initiating deployment in VISN 21.

Construction Programs.—The Administration's Fiscal Year 2021 request for VA's construction programs of \$1.9 billion dollars is a deeply disappointing retreat in funding to maintain VA's aging infrastructure. At the Senate Committee on Veterans' Affairs hearing on March 26, 2019, in response to Senator Manchin's question about VA's "decrease in funding levels for construction programs," Secretary Wilkie stated that he estimates VA will need, "\$60 billion over the next five years to come up to speed." This backlog is confirmed by VA's Fiscal Year 2021 budget submission, which states that VA's, "Long-Range SCIP plan includes 3,595 capital projects that would be necessary to close all currently identified gaps with an estimated magnitude cost of between \$49-\$59 billion not including activation costs." However, VA's Fiscal Year 2021 budget request for major and minor construction combined is just over \$1.9 billion, significantly below the true need stated by the Secretary and identified by SCIP. At a time when VA is seeking to expand its capacity by hiring additional doctors, nurses, clinicians and supporting staff, it is absolutely critical that VA continue to invest in the infrastructure necessary for them to care for veterans.

Some major construction projects have been on hold or in the design and development phase for years. Additionally, there are outstanding seismic corrections that must be addressed. Thus, the *IB* recommends \$2.7 billion for VA's Fiscal Year 2021 major construction, over \$1.4 billion more than VA's request.

To ensure VA funding keeps pace with all current and future minor construction needs, the *IB* recommends Congress appropriate an additional \$760 million in Fiscal Year 2021 for minor construction projects. It is important to invest heavily in minor construction because these are the types of projects that can be completed faster and have a more immediate impact on services for veterans. VA's Fiscal Year 2021 request of \$400 million is significantly less it has requested in previous years, and will only allow the critical infrastructure backlog to continue to grow.

Non-Recurring Maintenance (NRM) had seemed to slip through the cracks within the construction space in previous years. VA's Fiscal Year 2021 request of \$1.8 billion in budget authority for NRM, however, is a significant increase from previous years. NRM projects are often necessary maintenance that is preventative in nature and saves equipment and facilities from reaching failure points. Heavy investment in NRM is a wise expenditure because spending money to maintain equipment and buildings ensure longevity and costs a fraction of having to replace buildings with new construction. The *IB* is pleased VA has requested to invest in this critical concern.

A congressionally mandated research infrastructure report shows a total cost of \$99.5 million in Priority 1 deficiencies having an immediate need for correction within 1 year, such as correcting life-safety hazards, returning components to normal service or operation, stopping accelerated deterioration, and replacing items that are at or beyond their life cycle. The total cost to correct Priority 1–5 deficiencies is estimated at \$207.1 million. Accordingly, the *IB* recommends a minimum of \$99.5 million for Fiscal Year 2021 to correct all Priority 1 deficiencies.

Grants for State extended care facilities, commonly known as State home construction grants, are a critical element of Federal support for State veterans' homes. For Fiscal Year 2021, the *IB* recommends \$250 million for grants for State extended care facilities to fund approximately half of the Federal share of projects on the Fiscal Year 2020 VA State Home Construction Grants Priority List for Group 1, those that have already secured their required State matching funds.

National Cemetery Administration.—The *IB* commends the Administration for requesting a \$31-million-dollar increase in appropriations for NCA to account for its obligation to manage 156 national cemeteries and to meet a continued increase in demand for burial space which is not expected to peak until 2022. NCA continues to expand and improve the national cemetery system, to include a plan to open additional burial sites in 2021. NCA has also inherited 11 Army post cemeteries which it must perpetually maintain. VA's request of \$360 million for NCA operations and maintenance is \$24 million more than the *IB* recommendation of \$336 million.

Additionally, NCA has undertaken the task of creating a digital memorial page for each veteran interred in a VA national cemetery as part of the Veterans Legacy Memorial. This much needed expansion of the national cemetery system will help to facilitate the projected increase in annual veteran interments and will simultaneously increase the overall number of graves being maintained by NCA to more than 4 million by 2021. The *IB* strongly believe that VA national cemeteries must honor the service of veterans and fully support NCA's National Shrine initiative, which ensures our Nation's veterans have a final resting place deserving of their sacrifice to our Nation. The *IB* also support NCA's Veterans Legacy Program (VLP), which helps educate America's youth about the history of national cemeteries and the veterans they honor. Recently enacted P.L. 116–107, which authorizes NCA to provide grants as part of VLP, may enable VA to significantly expand VLP and ensure more veterans can have their stories preserved in perpetuity.

Administration Legislative Proposals.—The IBVSOs strongly oppose four benefits related legislative proposals included in the budget that would reduce benefits to disabled veterans that were earned through their service:

1. Effective Date Simplification for Claims for Increased Evaluation:

VA seeks to amend title 38, United States Code, § 5110(b)(3) to make the date of receipt of a claim the effective date for an increased rating. While VA states this is a simplification of claims for increase, this proposed amendment would take away billions of dollars from veterans by disallowing entitlement to an increased evaluation prior to the date of claim.

Title 38, United States Code, § 5110(b)(3) states, “the effective date of an award for increased compensation shall be the earliest date as of which it is ascertainable that an increase in disability has occurred, if application is received within one year from such date.”

For example, if medical evidence establishes entitlement to an increase rating eight months prior to the date the claim for VA benefits was submitted, the effective date for benefits granted will be that date eight months prior. By eliminating this statutory provision, VA would virtually discredit any medical evidence prior to the date of claim on claims for increase and negatively impact effective dates for individual unemployability. Not only would this bear directly on retroactive compensation, this proposal would also confound certain protections and other ancillary benefits based on effective dates.

The Administration's proposal would reduce anticipated disability compensation to veterans by \$678 million in 2021, \$3.5 billion over 5 years, and \$7.5 billion over 10 years. We strongly oppose this attempt to “simplify” effective dates for claims for increase particularly when the result will be billions of dollars in lost disability compensation for those who were injured or made ill in service.

2. Limit Disability Evaluations to Criteria within the VA Schedule for Disabilities (VASRD):

VA seeks to amend title 38, United States Code, § 1155 so that disability evaluations can only be established based on criteria within the VASRD and effectively eliminate extra-schedular consideration.

Extra-schedular cases are not defined by statute but in 38, Code of Federal Regulations, § 3.321(b)(1). It notes that to accord justice to the exceptional case where the schedular evaluation is inadequate to rate a single service-connected disability, an extra-schedular evaluation commensurate with the average impairment of earning capacity due exclusively to the disability is to be considered. The governing norm in these exceptional cases is a finding that application of the regular schedular standards is impractical because the disability is so exceptional or unusual due to such related factors as marked interference with employment or frequent periods of hospitalization.

The United States Court of Appeals for Veterans Claims (Court) has set out a three-part test, based on 38, Code of Federal Regulations, 3.321(b)(1) for determining whether a claimant is entitled to an extra-schedular rating: (1) the established schedular criteria must be inadequate to describe the severity and symptoms

of the claimant's disability; (2) the case must present other indicia of an exceptional or unusual disability picture, such as marked interference with employment or frequent periods of hospitalization; and (3) the award of an extra-schedular disability rating must be in the interest of justice. *Thun v. Peake*, 22 Vet. App. 111 (2008), *affd*, *Thun v. Shinseki*, 572 F.3d 1366 (Fed. Cir. 2009).

The VASRD does not contemplate every disease or disability, nor does it provide an evaluation for every set of symptoms and complications caused by each disability. This proposal would eliminate any veteran attempting to be afforded justice for the severity and symptoms of an unusual disability picture that provides marked interference with employment or frequent hospitalizations. This is an attempt to avoid the precedence as established by the Court.

The Administration's proposal would reduce anticipated disability compensation to veterans by \$74.7 million in 2021, \$1.1 billion over 5 years, and \$4.2 billion over 10 years. We strongly oppose this attempt to "simplify" effective dates for claims for increase particularly when the result will be billions of dollars in lost disability compensation for those who were injured or made ill in service.

We oppose any proposal that would eliminate extra-schedular consideration as it will not consider veterans' with unusual disability pictures based on marked interference with employment or frequent hospitalizations and effectively tip the scales of justice against them.

3. Round-Down of the Computation of the Cost-of-Living Adjustment (COLA) for Service-Connected Compensation and Dependency and Indemnity Compensation (DIC) for Five Years:

In 1990, Congress, in an omnibus reconciliation act, mandated veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress continued it until 2014. While not significant at the onset, the overwhelming effect of 24 years of round-down resulted in veterans and their beneficiaries losing billions of dollars.

In the Administration's proposed budget for Fiscal Year 2020, the Administration sought legislation to round-down the computation of COLA for 5 years. This would have cost beneficiaries \$34 million in 2020, \$637 million for 5 years, and \$2 billion over 10 years.

The Administration's proposed budget for Fiscal Year 2021 is seeking to round-down COLA computations from 2021 to 2026. The cumulative effect of this proposal levies a tax on disabled veterans and their survivors, costing them money each year. When multiplied by the number of disabled veterans and DIC recipients, millions of dollars are siphoned from these deserving individuals annually. All told, the government estimates that it would cost beneficiaries \$39 million in 2020 and \$677 million for 5 years and \$2.2 billion over 10 years.

Veterans and their survivors rely on their compensation for essential purchases such as food, transportation, rent, and utilities. Any COLA round-down will negatively impact the quality of life for our Nation's disabled veterans and their families, and we oppose this and any similar effort. The Federal budget should not seek financial savings at the expense of benefits earned by disabled veterans and their families.

4. Elimination of Payment of Benefits to the Estates of Deceased Nehmer Class Members and to the Survivors of Certain Class Members:

VA seeks to amend title 38, United States Code, § 1116 to eliminate payment of benefits to survivors and estates of deceased Nehmer class members. If a Nehmer class member, per 38 Code of Federal Regulations, § 3.816, entitled to retroactive benefits dies prior to receiving such payment, VA is required to pay any unpaid retroactive benefits to the surviving spouse or subsequent family members. This proposed legislation would deny veterans' survivors and families' benefits that would have otherwise been due to their deceased veteran family member as a result of exposure to these toxic chemicals while in service. It is outrageous that the Administration would deny compensation payments due to a surviving spouse. We adamantly oppose this or any similar proposal that may be offered.

The *IB* supports one of VA's legislative proposals regarding VA approved Medical Foster Homes (MFH). This proposal would require the VA to pay for service-connected veterans to reside in VA approved MFHs.

MFHs provide an alternative to long-stay nursing home (NH) care at a much lower cost. The program has already proven to be safe, preferable to veterans, highly veteran-centric, and half the cost to VA compared to NH care. Aligning patient choice with optimal locus of care results in more veterans receiving long-term care in a preferred setting, with substantial reductions in costs to VA. This proposal would require VA to include MFH in the program of extended care services for the

provision of care in MFHs for veterans who would otherwise encumber VA with the higher cost of care in NHs.

Many more service-connected veterans referred to or residing in NHs would choose MFH if VA paid the costs for MFH. Instead, they presently defer to NH care due to VA having payment authority to cover NH, while not having payment authority for MFH. As a result of this gap in authority, VA pays more than twice as much for the long-term NH care for many veterans than it would if VA was granted the proposed authority to pay for MFH. This proposal would give veterans in need of NH level care greater choice and ability to reside in a more home-like, safe environment, continue to have VA oversight and monitoring of their care, and preferably age in place in a VA-approved MFH rather than a NH. The proposal does not create authority to cover veterans who reside in assisted living facilities.

MFH promotes veteran-centered care for those service-connected veterans who would otherwise be in a nursing home at VA expense, by honoring their choice of setting without financial penalty for choosing MFH.

Thank you for the opportunity to submit our views on the Administration's budget request for VA. We firmly believe that unless Congress acts to increase VA's funding for Fiscal Year 2021 and 2022, veterans will be forced to wait longer for benefits and services leaving unfulfilled the promises made to those who have served and sacrificed defending our country.

Prepared Statement of Melissa Bryant

Chairman Takano, Ranking Member Roe, and distinguished members of the Committee on Veterans' Affairs, on behalf of National Commander, James W. "Bill" Oxford, and the nearly two million members of The American Legion, we thank you for the opportunity to testify on the Department of Veterans Affairs (VA) Budget Request For Fiscal Year 2021.

As VA moves forward to serve the veterans of this Nation, it is important that the Secretary have the tools and resources necessary to ensure that veterans receive the services they are entitled to in a timely, professional, and courteous manner – because they have earned it. The American Legion calls on this Congress to ensure that funding is maintained and increased as necessary to ensure the VA is preserved and enhanced to serve the veterans of the 21st Century, and beyond.

Provides Funding for Overall Mental Health

Post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) are the signature wounds of today's wars. Both conditions are increasing in number, particularly among those who have served in Operation Iraqi Freedom and Operation Enduring Freedom. The President's request for a 7.1 percent increase in funding will provide much-needed funding dedicated to this area. While veterans who served in Iraq and Afghanistan are not the largest group of VA's patient population, they require a disproportionate amount of VA specialized mental health services. There are nearly 3.5 million veterans who served after September 11, 2001.¹ The need for specialized mental health services will only grow.

In 2019, VA successfully hired more than 1,000 additional mental health providers with the Mental Health Hiring Initiative.² VA also increased same-day warm handoffs from the Primary Care Providers and Primary Care-Mental Health Integration providers by 19 percent, from 2016 through 2019, which resulted in 110,000 same-day primary care encounters in 2019.³ These actions have greatly increased the access and timeliness of quality mental health care for the Nation's veterans.

While The American Legion acknowledges advances in this area, there remains significant room for improvement. From the development of PTSD claims, through compensation and pension (C&P) examinations, to ultimate adjudication, The American Legion accredited representatives routinely see errors throughout the process. The American Legion's report, *The Road Home*, also indicates VA must continue to search for the most effective treatment programs for veterans with comorbidities of PTSD, and TBI with substance use disorder and chronic pain.⁴ Providers in VA must take care to prevent at-risk veterans from becoming dependent on alcohol or drugs used to "self-medicate."

¹ <https://www.census.gov/library/stories/2018/04/post-9-11-veterans.html>

² <https://www.va.gov/budget/docs/summary/fy2021VABudgetInBrief.pdf>

³ <https://www.va.gov/budget/docs/summary/fy2021VABudgetInBrief.pdf>

⁴ www.legion.org/sites/legion.org/files/legion/publications/60VAR0818percent20Thepercent20Roadpercent20Homepercent20-percent20TBI-PTSD.pdf

The American Legion believes VA must focus on mental health without sacrificing awareness and concern for other conditions afflicting servicemembers and veterans. As an immediate priority, VA must ensure staffing levels are adequate to meet the need. The American Legion also urges Congress to invest in research, screening, diagnosis, and treatment of PTSD and TBI. The president's proposed budget requests \$10.2 billion for veterans' mental health services, an increase of \$683 million (7.1 percent) above 2020. The American Legion supports this action as a positive step forward.

Prioritizes Funding for Suicide Prevention

The Budget also provides \$313 million, a 32-percent increase over the 2020 enacted level, to support the Administration's veteran suicide prevention initiatives, including the National Roadmap to Empower Veterans and End Suicide, a population-based, public health model encouraging partnerships at the national, regional, and local levels.

-A Budget for America's Future, Administration's Proposed Fiscal Year 2021 Budget

Suicide prevention and mental health is a top priority of The American Legion, VA, and the Department of Defense (DoD). The American Legion is deeply concerned by the high suicide rate among servicemembers and veterans. Veterans ages 18–34 are particularly troubling as their suicide rates have risen 76 percent from 2005 to 2017 with 44.5 veterans per every 100,000 dying by suicide each year.⁵ Women have become an increasing percentage of the veteran population which has grown 6.5 percent from 2005 to 2017. Unfortunately, the 2017 rate of suicide among women veterans was 2.2 times the rate among non-veteran women.⁶ In 2017, veterans accounted for 13.5 percent of all deaths by suicide among U.S. adults while only constituting 7.9 percent of the U.S. adult population.⁷ These statistics are disheartening as suicide among veterans has increased by 6.1 percent from 2005 to 2017 despite the national attention veterans suicide has received.

VA has taken great strides to reduce veteran suicide. Of particular note, VA expanded the Veterans Crisis Line (VCL), responding to over 650,000 phone calls every year, as well as thousands of electronic chats and text messages. The VCL has improved its ability to answer incoming calls from 70 percent in 2017 to 99.96 percent in 2019 with an average response time of an average of eight seconds or less.⁸ VA also hired more than 400 Suicide Prevention Coordinators (SPCs), mental health professionals that specialize in suicide prevention.⁹

The American Legion remains committed to working with Congress to reduce the high suicide rate among service members and veterans and is committed to finding solutions to help end this crisis. To ensure that all veterans are properly cared for at DoD and VA medical facilities, The American Legion, through Resolution No. 2 *Suicide Prevention Program*, has established a Suicide Prevention Program and aligned it under the TBI/PTSD Committee.¹⁰ This committee reviews methods, programs, and strategies that can be used to reduce veteran suicide. The work of this body will help guide American Legion policy and recommendations.

President Donald Trump's executive order, titled the "President's Roadmap to Empower Veterans and End a National Tragedy of Suicide" (PREVENTS), will require top officials from multiple government agencies to coordinate a strategy to tackle the issue of veterans suicide. The American Legion believes this initiative is a step in the right direction, but it must be properly coordinated with the activities of Congress and should not take any resources from VA to support itself.

Congress must ensure sufficient resources are available for effective VA suicide prevention efforts. Funding for the aforementioned programs must be provided as well as money for new programs. President Trump has called for a 32 percent increase in VA spending in Fiscal Year 2021, up to a total of \$313 million for suicide prevention. The American Legion appreciates the serious attention paid to this issue by the White House and urges Congress to appropriate these funds.

⁵ https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

⁶ Ibid

⁷ Ibid

⁸ Ibid

⁹ Ibid

¹⁰ archive. legion.org /bitstream /handle/ 20.500.12203/ 9286/2018S020.pdf ?sequence =1&is Allowed =y

Combats Military Sexual Trauma

Military Sexual Trauma (MST) refers to experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service. These actions are a gross betrayal of the trust between the men and women who serve in our armed forces and are more common than should ever be acceptable. National data exposes that about 1 in 4 women and 1 in 100 men stated that they experienced MST when asked by their VA provider.¹¹ Although rates of MST are higher among women, because there are so many more men than women in the military, there are actually significant numbers of women *and* men seen in VA who have experienced MST. However, these numbers do not even account for those who choose not to report MST or those who do not seek treatment from VA.

VA has taken significant steps to tackle the issue of MST. Every VA health care system now has a designated MST Coordinator who serves as a contact person for MST-related issues. This person can help veterans find and access VA services and programs. VA also provides treatment for physical and mental health conditions related to experiences of MST free of charge regardless of service connection.¹² The Veterans Benefits Administration (VBA), in response to a 2018 VA Office of Inspector General (OIG) report, updated their “PTSD Due to MST” training course and mandated training to be completed by March 2019 to ensure claims processors were trained adequately to adjudicate MST claims.¹³

The American Legion acknowledges that VA has made significant strides in handling the problem of MST, but work remains to be done. The American Legion uniquely understands the challenges VA faces to support survivors of MST due to our routine site visits through our System Worth Saving (SWS) program. This innovative partnership was launched in 2003 to promote best practices at VA Medical Centers (VAMC) and VA Regional Offices (VARO). During these visits, some critical issues we have witnessed include insufficient training of VA staff, lack of adequate time to process MST claims, high rate of attrition and compassion fatigue among VA staff who work on MST related issues, implications of bias and subjective ratings, and a continued culture of sexual harassment within VA facilities.¹⁴

The American Legion believes that our Nation’s veterans should never suffer at the hands of institutions whose existence and mission is to care for them. We believe in the quality of care at VA facilities and remain committed to a strong VA. The administration’s proposed budget requests \$10.2 billion for veterans’ mental health services, an increase of \$683 million (7.1 percent) above 2020, which includes MST related treatment. The American Legion appreciates the serious attention that MST has received and urges Congress to appropriate these funds.

Provides Critical Funding for IT

In 2021, OIT (Office of Information and Technology) is requesting \$4.912 billion, an increase of \$540.4 million (12.4 percent) over the 2020 enacted budget. This requested increase will support critical investments to Veteran-focused development, IT modernization and transformational efforts.

-Department of Veterans Affairs – Budget in Brief 2021

VA’s Information Technology (IT) infrastructure has been an evolving technological necessity over the past 40 plus years, sometimes leading the industry, and sometimes trailing. The American Legion has been intrinsically involved with VA’s IT transformation from the inception of Veterans Health Information and Technology Architecture (VISTA) to being a pioneer partner in the concept and integration of the fully electronic disability claims process, as well as through the new Project Advancing Telehealth through Local Access Stations, or ATLAS. Project ATLAS will enable remote examinations in selected American Legion posts, among other locations.

IT automation is expensive to implement and expensive to maintain, especially while working on legacy equipment. As in all digital space, IT infrastructure advances so quickly that most IT infrastructure is outdated by the time it is fully implemented, and VA’s IT infrastructure is no different. IT is inextricably intertwined into many of the services we take for granted, such as; telephone systems, appointment scheduling, procurement, building access, safety controls, and much more. Maintaining an up-to-date system is not a luxury, it is a necessity.

¹¹ https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

¹² Ibid

¹³ <https://www.va.gov/oig/pubs/VAOIG-17-05248-241.pdf>

¹⁴ <https://www.legion.org/systemworthsaving/reports>

The American Legion supports the continued effort by VA to update its systems. The president's budget provides \$4.9 billion for essential investments in IT to improve the online interface between veterans and VA. This includes major investments of over \$300 million to support the implementation of the MISSION Act, over \$250 million for Infrastructure Readiness Program, and over \$50 million for the VA Enterprise Cloud solution.¹⁵

The American Legion continues to call on Congress to consider funding that enables VA to tie all of their IT programs together. This should be a seamless architecture capable of processing disability and education claims, managing veterans' healthcare needs, integrating procurement needs so that VA leaders and Congress can analyze annual expenditures versus healthcare consumption. Additionally, patient information must be integrated into their profiles ensuring a seamless transition between the Department of Defense and VA.

Electronic Health Record Modernization (EHRM)

The request includes \$2.6 billion (an increase of \$1.2 billion or 82 percent from 2020) to continue VA's EHRM effort to create and implement a single longitudinal electronic health record from active duty to Veteran status, and to ensure interoperability with the Department of Defense (DoD).

-Department of Veterans Affairs – Budget in Brief 2021

The American Legion, through Resolution No. 83 *Virtual Lifetime Electronic Record*, has long endorsed and supported the VA in creating a Lifetime Electronic Health Records (EHR) system. Additionally, The American Legion has encouraged both DoD and VA to either use the same EHR system or, at the very least, utilize interoperable systems.

The American Legion recognizes the advantages of a bi-directional interoperable exchange of information between agencies. Collaborating with DoD offers potential cost savings and opportunities for VA. Opportunities include capitalizing on challenges DoD encounters deploying its own Cerner solution, applying lessons learned to anticipate and mitigate issues, and identifying potential efficiencies for faster and successful deployment. The American Legion supports the president's budget including \$2.6 billion as part of a multiyear effort to continue the implementation of a new EHR system.¹⁶ The EHR is a high-priority initiative that ensures a seamlessly integrated healthcare record between DoD and VA, by bringing all patient data into one common system. As such, we call on Congress to fund it accordingly.

Enhances Veteran Outreach

Outreach to veterans has been an ongoing issue for VA as it seeks to bring veterans into the VA system. For example, a recent VA health care utilization report found that only approximately 62 percent of all separated Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND) veterans have used VA health care since October 1, 2001.¹⁷ This has been documented for a variety of reasons such as not understanding what benefits and services they are entitled to, bad past experiences with VA services and facilities, or a general distrust of VA.

VA must do a better job reaching out to veterans to ensure they know what benefits and services they can receive. This is especially critical with the passage of new legislation, such as H.R. 299, the Blue Water Navy Vietnam Veterans Act of 2019, to ensure veterans have a clear understanding. VA must also take a proactive step with outreach to create an environment of trust with veterans that VA will take care of them with quality service. This is especially important when VA is trying to help underserved communities such as racial and ethnic minorities, women, and LGBT veterans. The administration's budget requests \$413.0 million for General Administration, \$57.1 million (16 percent) above 2020 which covers public relations and outreach. Specifically, the budget requests \$3.2 million in additional funds for the Office of Public and Intergovernmental Affairs.¹⁸ We call upon Congress to adequately fund these efforts to conduct outreach to veterans, including those of underserved communities, and for VA to utilize the funds fully and effectively.

¹⁵ <https://www.va.gov/budget/docs/summary/fy2021VAbudgetInBrief.pdf>

¹⁶ <https://www.va.gov/budget/docs/summary/fy2021VAbudgetInBrief.pdf>

¹⁷ <https://www.publichealth.va.gov/epidemiology/reports/oefoifond/health-care-utilization/>

¹⁸ <https://www.va.gov/budget/docs/summary/fy2021VAbudgetInBrief.pdf>

Further Implements the VA MISSION Act

The 2021 request fully supports continued implementation of the MISSION Act. The MISSION Act is fundamentally transforming VA healthcare by giving Veterans greater access to health care in VA facilities and the community, expanding benefits for caregivers, and improving VA's ability to recruit and retain the best medical providers.

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In response to veterans preference to receive medical services closer to their homes, Congress enacted the VA MISSION Act in 2018, a historic law that contains a number of policy priorities of The American Legion and other veteran stakeholders.¹⁹ VA MISSION Act, principally, reforms the Department of Veterans' Affairs care programs, including Choice, into a single Veterans Community Care Program (VCCP). MISSION Act requires VA to promulgate new access standards, and to develop strategic plans with completed market assessments to provide care to veterans under the new VCCP.

The budget includes \$18.5 billion in 2021, a 21 percent increase from 2020, for the Medical Community Care program. The American Legion supports the president in adequately funding the success of the consolidated community care program. We offer this support recognizing that VA must continue to properly allocate sufficient funding to maintain VA's existing healthcare infrastructure. Additionally, our support relies on the understanding that VA must expand capacity in locations where demand for care justifies additional VA infrastructure.

Ensures Proper VA Staffing

The 2021 request supports a total of 404,835 FTE, or 14,866 FTE above the 2020 estimated level to expand access to health care and improve benefits delivery. This includes clinical and hospital staff in the Veterans Health Administration (VHA), including physicians, nurses, and scheduling clerks. These dedicated employees come to work for America's Veterans and have a close connection with Veterans – over 33 percent are Veterans themselves. The 2021 request assumes a 1 percent pay raise.

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The American Legion has long expressed concern about staffing shortages at VA. Unfortunately, no easy solutions exist for VA to effectively and efficiently recruit and retain staff at VA healthcare facilities. The American Legion believes access to basic healthcare services offered by qualified primary care providers should be available locally, and by a VA healthcare professional, as often as possible.

It is important to understand that simply providing additional funding will not resolve the issue of staff shortages. The American Legion understands filling highly skilled vacancies at premiere VA hospitals around the country is challenging. VA has a variety of creative solutions available to them beyond additional legislative action. One such idea involves aggressively seeking public-private partnerships with local area hospitals. VA could expand both footprint and market penetration by renting space in existing hospitals, enabling VA to leverage existing resources and foster comprehensive partnerships with the community. Further, VA could research the feasibility of incentivizing recruitment at level 3 hospitals by orchestrating a skills sharing program that might entice physicians to work at level 3 facilities if they were eligible to engage in a program where they could train at a level 1 facility for a year every 5 years while requiring level 1 facility physicians to spend some time at level 3 facilities to share best practices.

The president's budget recognizes the need for additional staff and has proposed adding an additional 14,866 full-time employees above 2020 levels. The American Legion supports adding additional employees to ensure the timely delivery of services but urges the VA to simultaneously employ creative solutions to solve VA staffing issues as well.

Better Care for Women Veterans

The needs of a growing number of women Veterans mean that VA must provide more gender-specific primary care services, expand access to gynecology, and continue to identify and serve the health care needs for a unique Veteran population.

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¹⁹ VA Mission Act Pub. L. No: 115–182

Women are a vital component of the U.S. Armed Forces and have increasingly served in higher numbers than ever before. As a result, VA needs to be prepared for the sustained increase of younger female veterans as they complete their active service. The 2015 Department of Veterans Affairs Women Veterans Report noted that the total population of women veterans is expected to increase at an average rate of about 18,000 per year for the next 10 years.²⁰ While VA has made significant advancements in meeting the demands of an increasingly diverse veteran population, continued diligence is required to ensure that all veterans receive the high quality care they deserve.

VA must ensure that women veterans have access to quality gender-specific healthcare across the entirety of the network. Women veterans using VA care require knowledgeable providers in women's health to deliver comprehensive primary care services, including mental health, gender-specific care, and referrals for reproductive healthcare needs. The continued funding of a full-time Women Veterans Program Manager at every VHA health care system is essential to ensuring women veterans needs are met.

The American Legion continues to advocate for improved delivery of timely and quality healthcare for women using VA. Ensuring women veterans receive the quality care they deserve is a top priority of The American Legion. The president's budget recognizes the need for additional funding in this critical area, and has proposed an increase of \$53 million which is 9 percent over last year's authorization levels.

Military and Veteran Caregiver Services

Funding requirements for the CSP are driven by an increase in the eligible Veteran population. Currently, only Veterans injured on or after September 11, 2001 are eligible for this program. The 2021 request supports the expansion of this program under the MISSION Act to include eligible pre-9/11 era Veterans seriously injured in the line of duty.

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The struggle to care for veterans wounded in defense of this Nation takes a terrible toll on families. In recognition of this, Congress enacted, and President Barack Obama signed into law, the *Caregivers and Veterans Omnibus Health Services Act of 2010*. The unprecedented package of caregiver benefits was integral in ensuring America's veterans are properly care for.

The comprehensive package, however, was still not available to most family members who are primary caregivers to severely ill and injured veterans. Congress opened the program only to caregivers of veterans severely injured in the line of duty on or after Sept. 11, 2001.

The American Legion has long advocated for expanding eligibility and ending the obvious inequity that *Caregivers and Veterans Omnibus Health Services Act of 2010* created. All veterans should receive the same level of benefits for equal service. Thus, The American Legion supported the expansion of benefits to include all veterans who otherwise meet the eligibility requirements contained in the supports the expansion of this program under the MISSION Act. We urge this committee and the U.S. Congress to allocate the required funding to continue and expedite the expansion of the caregiver program to all eras of conflict and veterans who should be in this program. Moreover, we urge VA to swiftly implement the expansion of caregiver benefits with the funds that have been allocated by Congress. Failure to properly implement this expansion in the most expedited manner possible will only serve to perpetuate this obvious injustice.

The president's Fiscal Year 2021 budget requests \$1.2 billion for the Caregiver Support Program, a \$485 million (68 percent) increase over the 2020 levels. The American Legion supports this initiative and urges Congress to appropriate funds to ensure the expansion of benefits to veterans of all periods of service.

Additional Funding for State Approving Agencies

State Approving Agencies (SAAs) are responsible for approving and supervising programs of education for the training of veterans, eligible dependents, and eligible members of the National Guard and the Reserves. SAAs grew out of the original GI Bill of Rights that became law in 1944. Though SAAs have their foundation in Federal law, SAAs operate as part of State governments. SAAs approve programs leading to vocational, educational or professional objectives. These include voca-

²⁰ Women Veterans 2015, The Past, Present and Future of Women Veterans. "Women Veterans' Report." www.va.gov/vetdata/docs/specialreports/women_veterans_2015_final.pdf

tional certificates, high school diplomas, GEDs, degrees, apprenticeships, on-the-job training, flight training, correspondence training and programs leading to required certification to practice in a profession.

SAAAs currently employ 250 professionals across 56 states and territories and are responsible for over 9,000 facilities and more than 150,000 programs. SAAAs serve our veterans by protecting the quality and integrity of the GI Bill programs. These unique State agencies, funded by Federal contract through the VA, approve programs according to Federal and State requirements. They provide oversight to make sure schools remain compliant with those requirements through school visits and routine renewal of approval.

After being flat funded for over a decade at \$19 million dollars, Congress increased the funding of SAAAs to \$23 million dollars (\$3 million in discretionary funding has never been paid by VA and is not counted in the increase) in 2017. This amount of funding is far short of the needed increase to reflect the increasing complexity of administering the benefit given legislative changes and the rapid growth of beneficiaries driven by the Post 911 and Colmery GI Bills. This along with the increased cost of hiring and retaining personnel, to include rising health care and benefit costs (well over \$20,000 average per professional over the past decade) means that SAAAs continue to struggle to provide the needed service to and protection for veterans and their families. As such, we urge Congress to increase the SAA allocation from \$23 to \$30 million to allow these critical agencies to continue to provide approval and oversight of quality educational and training programs for our veterans.

Ensuring Quality Care to Rural Veterans

The budget requests \$270 million for rural health projects. VA is committed to improving the care and access for Veterans in geographically rural areas.

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It is imperative that VA ensures veterans have access to high quality care no matter where they live. Veterans who live in rural or highly rural communities often face difficulties when attempting to receive treatment. Although the implementation of the MISSION Act has allowed veterans to receive care in their communities, rural veterans still encounter challenges when seeking medical services.

VA's use of telehealth technology is integral in ensuring veterans who live in rural communities have access to VA services. As the largest integrated healthcare system in the United States, the VA provides telehealth at more than 900 sites across the country in over 50 areas of specialty care. In 2017, 45 percent of veterans who received care via telehealth lived in rural areas, yet many more veterans have limited access to this technology due to a lack of reliable connectivity. To ensure that more veterans have access to this technology, The American Legion has partnered with VA and Philips to bring telehealth technologies to local American Legion posts.

This program, known as Project ATLAS, will expand the availability of telehealth and allow veterans to be examined by a doctor in a familiar setting. Philips will install video communication technologies and medical devices in selected American Legion posts to enable remote examinations through a secure, high-speed internet line.

The American Legion's System Worth Saving task force travels the country to evaluate VA medical facilities and ensure they are meeting the needs of veterans. During each site visit, a town hall meeting is hosted by an American Legion Post. The town hall meetings have consistently illustrated that veterans are concerned about accessing care in rural areas as VA realigns services closer to population centers. The American Legion urges Congress to evaluate VA's plan in rural areas and to stop VA from closing hospitals and community-based outpatient clinics unless existing community services can meet or exceed the services VA currently provides.

The president's proposed budget requests \$1.3 billion for the total Telehealth program, an increase of \$271 million above the 2020 level. In 2022, VA is requesting \$1.7 billion, an increase of \$48 million above the 2021 level. The American Legion ardently supports this initiative and urges Congress to appropriate funds to bring affordable VA healthcare to veterans in rural areas through this program.

The Veteran Appeals Process

VA requests \$198 million in budget authority and 1,161 FTE for the Board of Veterans' Appeals (Board) to support its operations.

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The American Legion currently holds power of attorney on more than 1.3 million claimants. We spend millions of dollars each year defending veterans through the claims and appeals process, and our success rate at the Board of Veterans Appeals (BVA) continues to hover around 75 percent. Until President Trump signed the *Veterans Appeals Improvement and Modernization Act of 2017* (Appeals Modernization Act or AMA) at The American Legion's National Convention in Reno, Nevada, VA had a complex claims and appeals system.²¹

This "legacy" system divided jurisdiction amongst VA's three administrations and the Board of Veterans' Appeals (BVA). This confusing and complex process eventually led to extensive wait times and created a backlog. At the time, it was estimated it would take over 9 years to resolve the over 200,000 case backlog.²²

Recognizing this indefensible State of affairs, The American Legion worked with other stakeholders, VA, and Congress to develop the Appeals Modernization Act. The law created a new system with three review options:

- A "higher-level review" by a more senior claims adjudicator
- A "supplemental claim" option for new and relevant evidence
- An "appeal" option for review by the Board of Veterans' Appeals

Now, claimants may choose the option that best suits their needs. This new framework reduces the time it takes to review, process, and make a final claim determination, all while ensuring veterans receive a fair decision. Additionally, the Appeals Modernization Act framework includes safeguards to make sure claimants receive the earliest effective dates possible for their claims.

The Appeals Modernization Act became fully effective in February 2019. The AMA sets forth specific elements that VA must address in its implementation, including reporting requirements. For example, AMA requires VA to provide reports to Congress every 6 months. VA's last report to Congress was in August 2019, so the best information available is six months old.²³ According to that report, the Veterans Benefits Administration has a clear path to a sustainable steady State workload by 2022.

However, the Board of Veterans' Appeals (BVA) did not report information on the AMA workload in that report and it is unclear if the BVA is on a path to sustainable performance or how long it will take to get there or whether it has adequate resources. We need a lot more data about inflows, outflows and inventory for every docket in the BVA, including the legacy docket and all three AMA dockets. VA must provide stakeholders and Congress clear metrics to measure the progress and success of appeals and claims reform and strengthen Congress's ability to hold VA accountable for meeting these metrics.

Medical and Prosthetic Research

The 2021 request for the Medical and Prosthetic Research appropriation is \$787 million, an increase of \$37 million, or 5 percent, from 2020...

VA has among the richest health datasets in the world, including those associated with the Million Veteran Program (MVP). These datasets hold information that will benefit both Veterans and the Nation. To accelerate the rate of these discoveries, VA is taking the steps necessary to ensure that research with a translational trajectory will be conducted at larger scale.

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The American Legion believes VA research must focus on improving treatment for medical conditions unique to veterans. Because of the unique structure of VA's electronic medical records (VISTA), VA Research has access to a great amount of longitudinal data incomparable to research outside the VA system. Because of the ongoing wars of the past two decades, several areas have emerged as "signature wounds" of the Global War on Terror, specifically Traumatic Brain Injury (TBI), Posttraumatic Stress Disorder (PTSD), and dealing with the effects of amputated limbs.

Much media attention has focused on TBI from blast injuries common to Improvised Explosive Devices (IEDs) and PTSD. As a result, VA devoted extensive re-

²¹ Veterans appeals Improvement and Modernization Act of 2017, Pub. L. No: 115–55.

²² VA Debt Management Brief, Office Of Management, "Department of Veterans Affairs Debt Management and Collections" drive.google.com/file/d/0B70_mGYT1tJETzZGWUZKYzdGXzg/view

²³ http://www.veteranslawlibrary.com/files/VA_Appeals_Modernization_Update_August_2019.pdf

search efforts to improve the understanding and treatment of these disorders. Amputee medicine has received less scrutiny but is no less a critical area of concern. Because of improvements in body armor and battlefield medicine, catastrophic injuries that in previous wars would have resulted in loss of life have led to substantial increases in the numbers of veterans who are coping with loss of limbs.

America's disabled veterans depend on VA maintaining its reputation as the leader in prosthetics care and service. VA has a reputation in the United States and around the world of providing the best possible prosthetic care to its disabled veterans. However, The American Legion remains concerned that once these veterans transition away from active duty status to become veteran members of the communities, there is a drop-off in the level of access to these cutting edge advancements.

Reports indicate the state-of-the-art technology available at DoD sites is sometimes not available through a VA Medical Center. With so much focus on "seamless transition" from active duty to civilian life for veterans, this is one critical area where VA cannot afford to lag beyond the advancements reaching service members at DoD sites.

The American Legion urges Congress to ensure appropriations are sufficient to meet the prosthetic needs of all enrolled veterans. We believe the VA must continue to protect all funding for prosthetics and sensory aids. The VA must maintain a dedicated, centralized funding prosthetic budget to ensure the continuation of timely delivery of quality prosthetic services to the millions of veterans who rely on prosthetic and sensory aids' devices and services to recover and maintain a reasonable quality of life.

Finally, The American Legion is supportive of VA's landmark Million Veteran Program (MVP) research effort. MVP is a national research program to learn how genes, lifestyle and military exposures affect health and illness. MVP-based studies focus on topics including PTSD, suicide prevention, heart disease and diabetes. Findings from several studies have appeared in high-impact medical and scientific journals. More than 800,000 veterans are already enrolled in MVP, and the recent launch of online enrollment has made it easier for more veterans to take part.²⁴

Assisting Homeless Veterans

The VA requests approximately \$1.9 billion for homeless programs, \$82 million above 2020. The 2021 request includes an increase of \$30 million for case management for the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program.

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The American Legion strongly believes that homeless veteran programs should be granted increased funding to provide supportive services such as, but not limited to: outreach, health care, rehabilitation, case management, personal finance planning, transportation, vocational counseling, employment, and education. Additionally, we urge VA to leverage all monies appropriated to them by Congress to ensure continued progress in the fight against veteran homelessness.

The American Legion continues to place special priority on the issue of veteran homelessness. With veterans making up about 11 percent of our Nation's total adult homeless population, there is reason to give this issue special attention. Along with various community partners, we remain committed to seeing VA's objective of ending veteran homelessness achieved. Our goal is to ensure that every community across America has programs and services in place to get homeless veterans into housing (along with necessary healthcare/treatment) while connecting those at-risk veterans with the local services and resources they need.

State Veteran Home Construction Grants

Perhaps no program facilitated by the VA has been as impacted by the decrease in government spending than the State Veteran Home Construction Grant program. This program is essential in providing services to a significant number of veterans throughout the country at a fraction of the daily costs of similar care in private or VA facilities. States are pivoting toward resuming essential services, taking advantage of depressed construction costs, and meeting the needs of an aging veteran population, greater use of this grant program will continue. As our baby boomer population continues to transition into retirement, many more of these veterans are retiring to State veteran homes due to their excellent reputation for care and cost. The popularity of these retirement options will cause any surplus of space to become

²⁴ <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5387>

consumed. The American Legion encourages Congress to increase the funding level of this program.

National Cemetery Administration (NCA)

No aspect of the VA is as critically acclaimed as the National Cemetery Administration (NCA). In the 2010 American Customer Satisfaction Index, the NCA achieved the highest ranking of any public or private organization. In addition to meeting this customer service level, the NCA remains the highest employer of veterans within the Federal Government and remains the model for contracting with veteran-owned businesses.

While NCA met their goal of having 90 percent of veterans served within 75 miles of their home, their aggressive strategy to improve upon this in the coming five years will necessitate funding increases for new construction. Congress must provide sufficient major construction appropriations to permit NCA to accomplish this goal and open five new cemeteries in the coming five years. Moreover, funding must remain to continue the expansion of existing cemetery facilities as the need arises. Additionally, it is imperative that Congress continue to appropriately fund the Veterans Legacy Program, which honors our nations veterans by educating America's youth on the service and sacrifices of those veterans interred at national cemeteries. The American Legion urges Congress to adequately fund all programs to meet the burial needs of our Nation's veterans.

Advance Appropriations for Fiscal Year 2022

The 2022 Medical Care Advance Appropriations request includes a discretionary funding request of \$98.9 billion (with medical care collections). The 2022 mandatory funding request is \$145.3 billion for veterans benefits programs (Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities).

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The VHA manages the largest integrated health-care system in the United States, with 170 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, Vet Centers and domiciliary serving over 9.2 million enrolled veterans. The American Legion believes those veterans should receive the best care possible.

If veterans are going to receive the best possible care, the system needs to continue to adapt to the changing demands of the population it serves. The concerns of rural veterans can be addressed through multiple measures, including expansion of the existing infrastructure through CBOCs, MISSION Act initiatives, improvements in telehealth and telemedicine, improved staffing and enhancements to the travel system, and other innovative solutions.

Patient concerns and quality of care can be improved by better attention to VA strategic planning, concise and clear directives from VHA, improved hiring practices and retention, and better tracking of quality by VA on a national level.

And finally, mandatory funds must be included in Advanced Appropriations along with full discretionary funding of all VA accounts. Veterans and dependents having their compensation and disability checks delayed because Congress refuses to pass an annual budget before being forced to close the Federal Government is reprehensible. Pass full advanced appropriations now.

Conclusion

In closing, The American Legion appreciates the leadership of this committee and remains committed to ensuring VA has the necessary funds, resources, and staff to carry out its mission of caring for our nations veterans. Further, The American Legion is committed to working with the Department of Veterans Affairs and this committee to ensure that America's veterans are provided with the highest level of support and healthcare.

Chairman Takano, Ranking Member Roe, and distinguished members of this committee, The American Legion thanks this committee for holding this important hearing and for the opportunity to explain the views of the nearly 2 million members of this organization. For additional information regarding this testimony, please contact Ms. Melissa Bryant, Legislative Director, at MBryant@legion.org or (808) 263-2981.

