US DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2020

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

WEDNESDAY, APRIL 3, 2019

Serial No. 116–4

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
38–954 WASHINGTON : 2021

COMMITTEE ON VETERANS' AFFAIRS

MARK TAKANO, California, *Chairman*

JULIA BROWNLEY, California
KATHLEEN M. RICE, New York
CONOR LAMB, Pennsylvania, *Vice-Chairman*
MIKE LEVIN, California
MAX ROSE, New York
CHRIS PAPPAS, New Hampshire
ELAINE G. LURIA, Virginia
SUSIE LEE, Nevada
JOE CUNNINGHAM, South Carolina
GILBERT RAY CISNEROS, JR., California
COLLIN C. PETERSON, Minnesota
GREGORIO KILILI CAMACHO SABLAN, Northern Mariana Islands
COLIN Z. ALLRED, Texas
LAUREN UNDERWOOD, Illinois
ANTHONY BRINDISI, New York

DAVID P. ROE, Tenessee, *Ranking Member*
GUS M. BILIRAKIS, Florida
AUMUA AMATA COLEMAN RADEWAGEN, American Samoa
MIKE BOST, Illinois
NEAL P. DUNN, Florida
JACK BERGMAN, Michigan
JIM BANKS, Indiana
ANDY BARR, Kentucky
DANIEL MEUSER, Pennsylvania
STEVE WATKINS, Kansas
CHIP ROY, Texas
W. GREGORY STEUBE, Florida

RAY KELLEY, *Democratic Staff Director*
JON TOWERS, *Republican Staff Director*

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Wednesday, April 3, 2019

US DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2020

Wednesday, April 3, 2019

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

The Committee met, pursuant to notice, at 2:20 p.m., in Room 1334, Longworth House Office Building, Hon. Mark Takano, [Chairman of the Committee] presiding.

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

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good afternoon. I call this hearing to order.

First, I'd like to welcome Secretary Wilkie and our Veterans service organizations, the American Legion, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars to this hearing on the President's Fiscal Year 2020 Budget Request.

This budget reflects the Administration's priorities, many of which we can all agree upon. The fact that we can agree on so much is a bright spot in the function of this chamber and our government.

However, in some cases we continue to see the same proposals from this Administration that we will never support. Proposals like taking disability benefits from veterans by rounding down the cost of living adjustment to pay for other veterans' programs.

The VA budget does not contain the proposed cuts to its programs and benefits that we see in other parts of the President's fiscal year 2020 budget request.

Yet we cannot forget that cuts to important safety net programs like SNAP benefits, Medicare, and Medicaid, and the agencies responsible for providing them will have serious impacts on the lives of veterans and their families who depend on those benefits, and will likely place a greater strain on VA resources as veterans look to fill the void these programs have left.

Although VA's budget reflects an overall increase of 9.5 percent over Fiscal Year 2019 appropriate levels, I remain concerned about whether this budget provides appropriate levels of funding to implement the VA MISSION Act, address VA's information technology needs and provide Blue Water Navy veterans exposed to Agent Orange disability and health care benefits, and address vet-

eran suicide, including an alarming trend of veterans committing suicide on VA campuses.

Now, we are all aware of the significant challenges at VA and our task today is to ascertain whether this budget request goes far enough to address these challenges, and whether funding has been prioritized to best support the needs of veterans.

For example, with the passage of the MISSION Act, implementation of the law and providing coordinated community care has been a focus of the Department. However, funding for this program and the prioritization of this program must not be done at the expense of addressing VA's significant workforce and infrastructure needs.

Based on the Congressional Budget Office's cost projections, we do not know if this budget request goes far enough to cover the projected cost of this program, an estimated $47 billion over five years without pulling resources from other VA programs.

The hasty rollout of IT systems and programs like Medical Surgical Prime Vendor without involving the clinicians and users of these systems, or having the leadership and governance in place has led to disruptions in services, and we are afraid problems with the delivery of care and benefits to veterans may continue without the appropriate leadership commitment, expertise, and resources.

Most recently we witnessed this with a disruption to student veterans GI Bill Housing Stipend benefits.

The VA includes a hefty increase of $426 million to prevent veteran suicide. Yet, last year VA spent only $57,000 on suicide prevention outreach to veterans. It took oversight from the Inspector General and this Committee to get the VA back on track. The budget request includes an additional $15 million for suicide prevention outreach and if VA receives this funding, I intend to closely monitor spending of these funds to ensure that every last cent is spent to get the word out to veterans in crisis.

If we are to be successful in preventing 20 veterans from taking their lives each day, veterans must have easy access to VA mental health care, and they must know that VA is ready and immediately available to help when veterans need it most.

The VA must be prepared to provide disability benefits and health care to the Blue Water Navy veterans who have been waiting over 40 years for their benefits. It must invest in its workforce, including recruitment of providers to fill the 48,985 vacancies in the department, and address severe morale issues at some facilities.

VA contracting has now been added to the Government Accountability Offices' high-risk list, and the Veteran's Health Administration has remained on that list since 2015. These challenges play out each day at the D.C. VA Medical Center, practically footsteps from the White House.

The D.C. VA was in the news again last night because of low morale, severe understaffing, and a dysfunctional medical supply chain. Meanwhile, the clinicians and front-line staff at that hospital make do with limited resources and support to provide high quality and timely care to veterans. We wanted to know which funds in the budget are requested to address these challenges.

Then we talk about student veterans, who have been robbed of their time and GI Bill benefits by predatory for-profit schools and

must be made whole. The recent closings at Argosy campuses have left thousands of veterans in limbo. Congress was forced to step in two years ago to restore benefits to veterans affected by for-profit schools closing, such as ITT Tech and Corinthian, and we may have to do it again.

But the Department has a role in preventing these schools from taking advantage of veterans in the first place. We need to know how VA's budget addresses this problem. And finally we need to understand the Administration's rationale for the proposed $17 million cut to VA research, and 45 percent cut to VA's construction budget, which is contrary to what our veteran service organizations recommend.

I have invited them here today so that they can weigh in on what they believe to be the appropriate funding levels and priorities for VA.

Now these challenges are not insurmountable and as I said in our last hearing we are to work with VA as a partner to ensure VA can meet these challenges now and in the future. To do that, we need transparency from VA so that we can have an open and honest dialogue about the resource needs of the Department, and today we are here to conduct oversight so that Congress, veterans, and the American people all understand our investment in the VA and ensure the funds that we provide are used to support the needs of veterans.

I see that I started the hearing without Dr. Roe here, and I'm sorry I did that. I'm sorry. So what I will do is I want to recognize the Secretary for his opening comments and then I'll recognize Dr. Roe when he arrives.

STATEMENT OF ROBERT WILKIE

Secretary WILKIE. Mr. Chairman, I'll stop when Dr. Roe comes. Thank you again for your courtesy to me. This is my second appearance in the last, I think, month in front of the Committee and I am pleased to present to you the largest budget recommendation in the history of our department. I am very happy to be here with veterans. Jon Rychalski, who is our Chief Management Officer; Dr. Richard Stone, who is our Executive in Charge of health and the recent award winner for outstanding senior executive in the Federal government; Dr. Paul Lawrence who works for our VBA.

I have said before, Mr. Chairman, that we are in the middle of the greatest transformative period in the history of our VA. We are no longer on the cusp; we are in the middle. And that is, in part, because of the leadership of this Committee and your companion in the United States Senate.

We are also very happy to report in response to some of the things that you pointed out that morale at VA is at an all-time high. For the first time in my professional career the Department of Veterans Affairs is no longer 16 out of 17, or 17 out of 17 when it comes to the best places in government to work. We are at sixth place and we are rising.

In addition, our veterans are voting with their feet. The satisfaction rate for America's veterans for the services that they get at the Department of Veterans Affairs has now reached 90 percent.

That is also my response to those who say that we are in the middle of privatizing this wonderful institution. Our veterans are telling the world that they are getting the best service in the country from their VA, and I am very proud to be part of that team.

I will be short then and allow Dr. Roe to take his usual place, but I did want to finish. I'm not giving you an extensive statement since I did that a few weeks ago, but to respond to something that you raised during your hearing yesterday with Dr. Stone, and that was questions about community care and our ability to carry forth with the payment of our doctors and community medical facilities if contracts are under challenge.

I am happy to say that because of the military training that all of us at this table have that we believe in redundancy, and TriWest is responsible for handling those accounts until a new contract is in place and people are working those new contracts. So there is not going to be an interruption in service.

Our new community care contracts are coming into place and there will be no gap between what TriWest has been doing and what our new partners will be doing when it comes to fulfilling our community care obligation.

So I will stop and not give a lengthy opening statement and yield to Dr. Roe.

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

Mr. CHAIRMAN. Thank you, Mr. Secretary. Before I recognize Dr. Roe, without objection Mr. Mast will be permitted to sit at the dais and ask questions when recognized. I now recognize Dr. Roe for his opening statement.

Mr. ROE. Mr. Chairman, I think what we can do, and we have a long hearing this afternoon. I'll just submit it for the record, and we can move on.

[THE PREPARED STATEMENT OF DAVID P. ROE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Roe. We've already heard from the Secretary. I would like now to recognize myself for five minutes, and I want to begin with a question to Secretary Wilkie.

Mr. Secretary, I understand from an interview you did with the Colorado Public Radio station that you said, and I quote, "I refute everything in that report," and I'm referring to the report by the U.S. Digital Service. You go on to say, "that's an interesting report that was done without discussing any of the issues with any senior leader at the Department of Veterans Affairs, including the people who actually handle our information technology systems."

In a hearing this Committee held yesterday, Dr. Glynn, the Assistant Secretary for the Office of Enterprise Integration confirmed that she herself requested the report from the United States Digital Service and said it was standard practice for VA to request such a report from subject matter experts, and requested a briefing that was attended by VA senior staff to discuss the report's findings.

So do you still stand by your assertion that no senior leaders or individuals handling the information technology systems were briefed or took part in discussions with USDS?

Secretary WILKIE. I do, and I'm talking about process, Mr. Chairman. That report was in pro publica before any of us saw it. It was a draft report. It was not a complete report. What was interesting to me is that for an organization that specializes in high tech, 80 percent of the draft report was about policy.

Having grown up in this institution I know what would have happened in the Majority Leader's office in the Senate where I worked, if we had a report that was incomplete and was in the press before the Majority Leader saw it.

That was the thrust of my remarks that it is bad process for me and for the leaders at this table to read about a report in pro publica before any of us have ever seen it.

So I was talking about process and I was saying that I refute the process that was involved in releasing that before any of us at the table saw it.

The CHAIRMAN. So you were not refuting the content in that report?

Secretary WILKIE. I don't refute all of it, no. I was talking about the process in which I found out about it.

The CHAIRMAN. I see. Well, you know, Dr. Roe the Ranking Member and I both sent you a letter on March 21, and I'm holding the letter in my hand, requesting that the VA provide all U.S. Digital Service reports on VA systems for the last five years, and without objection I'm going to enter this letter and the response that we received from you on March 29, and I'm holding your response right here—the March 29 response from you into the record. So without objection I enter both documents in the record.

After the deadline of March 28, we received your response, and this is that response I'm speaking of, that VA could not provide these reports to us because they belong to OMB. However, we discussed these reports with OMB, and this is not true.

These reports are VA documents. Will you provide Ranking Member Roe and me with these reports by the close of business this Friday, April 5?

Secretary WILKIE. First of all, Mr. Chairman, I understand that the White House counsel itself wrote that letter and anything that's in VA's purview to hand to this Committee, I will hand to this Committee.

The CHAIRMAN. So we can expect these reports by Friday?

Secretary WILKIE. Anything that is in our purview to hand to you, I will do that.

The CHAIRMAN. I appreciate that, but specifically the U.S. Digital Service Reports that we've asked for the past five years. That's what I'm asking. I understand those to be in VA's possession.

Secretary WILKIE. And I don't know all of the details, but you've got my promise that if we have the authority to release things that are in our custody, I will release them.

The CHAIRMAN. Well, my understanding is that they are in your custody and that it is the purview of the oversight of this Committee to request and be able to receive those reports and I will expect those reports by Friday.

I see that I'm running out of time. I had wanted to ask you about the Loma Linda Medical Center, but I hope we can dialogue more about that, but I will now recognize Ranking Member Roe for his five minutes.

Mr. ROE. Thank you, Mr. Chairman. I'm going to yield at this time to Mr. Banks.

Mr. BANKS. Thank you, Mr. Chairman and Ranking Member Roe. First of all, Mr. Secretary and Dr. Stone, I would just like to add that I, too, think that the U.S. Digital Service makes a valuable contribution.

Technology is one of our government's biggest struggles and the members of USDS are some of the best and brightest from the private sector coming to work with Federal agencies each and every day. Just because USDS may have gotten outside of their lane in this particular report, and some of their recommendations were taken out of context, I don't believe that they should be discredited.

So, Mr. Secretary, do you intend to continue working with USDS in the future?

Secretary WILKIE. Yes, sir, and I wasn't discrediting their work. I was simply saying that I was asked to respond to something that I had never seen, and I think you know from your political life that is a very interesting place for a leader to be in.

Mr. BANKS. Fair enough. Let me move on to something else, Mr. Secretary. The VA is now adopting DoD's logistics software demos at the James Lovell Medical Center to harmonize the two supply chains.

I agree with this concept, though I'm worried about adding demos onto the EHR modernization too early. How exactly is this software different from what you have now and what else will it enable you to do?

Secretary WILKIE. Well, it is also a process question. What is different now is that we have systems that are spread out throughout the Department of Veterans Affairs. We don't have a single comprehensive supply chain management system.

We have different parts of the country—different medical centers asking for things in an inchoate way. I testified in front the Senate a few weeks ago that we actually—I came across warehouses of material that had been ordered willy-nilly without any centralized accounting system to make provision for them.

What this will do is create a nationwide system that will allow our people to punch into it and put in requests that they need, and we will be able to distribute supplies and material across the country to meet the greatest need.

I would be lying to you if I told you I was an expert in IT. But having been on the other side as the Undersecretary of Defense, I know how well that system works.

I want it to work for us because we're not going to be able to do—if everything in the MISSION Act worked perfectly, if we don't have a modern supply chain system, a modern HR system and the electronic health record, it's going to be difficult to continue the progress VA has been making.

Mr. BANKS. Let me follow up on that. The OIT budget proposal allocates $36.8 million for this supply chain initiative. Is that just the cost for the pilot site or to purchase demos in VA across—

Secretary WILKIE. That's the cost of the pilot site.

Dr. STONE. Yes, sir, that is the cost of the pilot site. There are nine different subsystems within supply in maintenance that are held within the supply chain. So how we maintain the services on our major end items like CT scanners and MRIs, right down to how we buy Band-Aids. So there's nine different subsystems.

Right now what we discovered when we arrived is that about 36 of our medical centers that are on a system called Sword Maximo, that was not propagated across the rest of the system.

What see in demos is an opportunity to combine closely with Department of Defense and really leverage the power of both departments against potential savings for the American taxpayer.

Mr. BANKS. Okay. So $36.8 million is the cost of the pilot. How much will demos and the rest of the supply chain initiative cost when it's rolled out nationally? And when will that national rollout occur?

Dr. STONE. So we will break the code on how we've done it north Chicago about mid-May and begin to look at the financial implications of it. Should it make sense we'll then go forward in the initial operating sites in Spokane and Seattle and at that point we'll step back and see if we can—

Mr. BANKS. If we're making an investment of $36.8 million for a pilot site, what can we expect the cost totally when it's rolled out nationally?

Dr. STONE. It would be our hope that this can be self-funded. That is the plan, is to try and self-fund this initiative from savings in the supply chain.

Mr. BANKS. My time is almost expired. I'll yield back.

Mr. RYCHALSKI. One comment about that is we are doing the cost analysis now. One point here is demos is a fully mature system, so we have pretty good cost information. We also don't have to develop anything so it's a matter of installing the system. We can provide you cost estimates frankly for the continuation once we have them later this year.

Secretary WILKIE. And I would add, sir, if the Chair would indulge me because Chairman Takano mentioned this in his opening remarks. My impetus for moving was precisely the situation that the Chairman laid out.

I was familiar with what was going on at the D.C. VA. The stories in the Washington Post about how operating room technicians running across the parking lot to MedStar to get equipment that they should have had. You cannot run a modern organization without a modern supply chain, especially for an organization that has 170 hospitals.

The CHAIRMAN. I now recognize Ms. Brownley for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you, Mr. Secretary for being here today and thank you for your visit to my office last week. I enjoyed it very, very much.

I have two questions that I want to ask and both questions are under the umbrella of IT, one for the MISSION Act and the other for the electronic health care records.

So, the first on the MISSION Act and its implementation. I, too, as some members have already expressed was very concerned at yesterday's hearing, having read the USDS report and I under-

stand what you're saying. It's never fun to have the press out in front of you. I get that.

And as you said it's a draft and somewhat incomplete, but there were still some very alarming issues that were raised within that report and I think it actually put our oversight responsibilities on sort of high alert.

I also recognize that you have written a letter to the Appropriations Committee about an increase in funding for MISSION Act implementation.

And so given the concerns from yesterday's meeting I actually have a letter that I wrote to you that I'd like to deliver to you today just asking some follow-up questions with regard to the IT systems and the implementation of the MISSION Act, and if you would be so kind to respond to me, I'd appreciate it.

Secretary WILKIE. I will, and I also thank you for the visit. Let me answer quickly about what will happen on June 6.

I mentioned a few minutes ago the issue of redundancy in military systems. That's how I was trained. I expect a decision support tool which was mentioned in that report to be online on June 6. It is a tool for our doctors and health care professionals at VA. It is not a tool for our veterans' community to use. It is for the doctors to determine in consultation with the veteran what the best health care outcome is, where to go. So, that is that.

The other side is we're going to be implementing MISSION Act even if the decision support tool is at 70 percent or 50 percent. Our people have been trained on how to work with our veterans in getting the accessibility and availability standards to them and to get them out into the community if we do not have that particular service.

Ms. BROWNLEY. And Dr. Stone said the same thing yesterday, as well. But still some concerns obviously and we don't have—I think it's fair to say that we don't have the greatest reputation when it comes to IT implementation.

But second question around the MISSION Act is I know that your people are meeting with our Committee staff I think on a monthly basis and now that we're in essence three months away from the MISSION Act rollout, I was hoping that we, and I think staff is, and I think the Chairman supports me in this request in terms of having more frequent briefings with the Committee staff just so that we can have some greater oversight.

And would you agree to in these next few months to provide the Committee staff with biweekly updates rather than monthly updates?

Secretary WILKIE. Yes.

Ms. BROWNLEY. Thank you, sir.

Secretary WILKIE. And anything you need on that.

Ms. BROWNLEY. Thank you very, very much. And then my last question is with regard to the electronic health record.

Yesterday we had a hearing with the IG and GAO and I believe it was the GAO who said—I'm paraphrasing, but the gist of what she said was that if DoD and the VA don't square off on the issues and issues that have to be adjudicated, if that can't be done, implementing the electronic health record is going to fail. Period.

And so that also raised my hackles and I think it did for everyone on the Committee and, you know, obviously again our oversight on that is on red alert, as well. Your comments?

Secretary WILKIE. Actually I would agree with the statement that says if we can't agree with DoD then the process is in trouble. I would not have embarked on this if I thought that was a potential.

I mentioned that the precursor to this was me sitting with Secretary Mattis and we were finally able to say to both the DoD and the VA community that we will deliver a continuum of care from the time that a young American walk into the entrance processing station, and the time that that American is handed over to VA.

I am looking at making the Integrated Program Office much more robust. It's worked in more complex defense programs than the electronic health record. I think it will be the coming together for the first time of two major departments of the Federal government for a common system. I'm absolutely confident that we're going to get this onboard and I will again use the personal impetus for me proving this. Days of people like my father with an 800-page paper record walking around have to be over.

Ms. BROWNLEY. You will be the first to break through these silos, so we are all counting on you. Thank you very much and I yield back.

The CHAIRMAN. I'm going to recognize Dr. Roe for five minutes.

Mr. ROE. Thank you all. Thanks for being here. Dr. Warren, she's very quickly—we're about six weeks into appeals modernization. How is that going?

Dr. LAWRENCE. Very well. The experience you had when you were down in Nashville has been validated. One month in I think we received about 1,100 of new appeals and those— some of them have been processed within 30 days. So far so good. Some tweaks, we're doing some after action but we're going forward as planned.

Mr. ROE. I think that is a real ongoing success story for VA and one that folks should know about.

I had an opportunity, Mr. Secretary, to go through the budget and as we go into the MISSION Act, what's the total budget for non-VA care?

Secretary WILKIE. The total budget, and I'll give you the percentage, Dr. Roe, is about 19.1 percent with 81 percent being within VA, and that meets the trends that you and I have discussed, and I mentioned earlier that we foresee veterans continuing to vote with their feet and come to VA. I think that 81–19 split is perfectly in line with that.

Mr. ROE. In real dollars how much is that?

Mr. RYCHALSKI. So for the consolidated community care it's about—in purchasing power it will be about $16.8 billion.

Mr. ROE. Okay. I just wanted to—and that pretty well, if you looked at the six other ways that VA had to provide care and add that to what we provided with choice, I think that's about where that number—am I correct on that?

Mr. RYCHALSKI. That's correct.

Mr. ROE. Okay. The second question I have is I was looking at the budget and we know VA's record on major construction projects

has been less than stellar. I noticed there was a $2 billion in a new—what's that $2 billion for?

Mr. RYCHALSKI. Two billion dollars in new construction?

Mr. ROE. Yes, sir.

Mr. RYCHALSKI. I think some of it was—it was in major and minor construction. I think there was 1, maybe 1.2, some of that for Louisville. I think New York, Manhattan. I'll have to look at the other projects.

Mr. ROE. Are these new hospitals that we're building?

Secretary WILKIE. The Louisville hospital is new and Manhattan is a complete overhaul.

Mr. ROE. Okay. Well, I know my good friends in Kentucky will probably not like me saying this, but should we be thinking about looking at the Air Act and has that been taken into consideration? Maybe they're both needed and it's great if they do. We got it. We need to go ahead.

But the question is does that fall into the market assessments that we've done and let's don't lay out $2 billion worth of new construction and find out five years from now we goofed up?

Secretary WILKIE. Well, yes, sir. I am almost as vocal a proponent of the market assessments and the Air Commission as you are. This is the wave of the future. We are conducting the market assessments as we speak.

My understanding is that the requests for Louisville and Manhattan long predated my tenure here. But it is my intention to come to this Committee in the near future as the market assessments are completed and actually ask for the Air Commission to begin its work in a time sooner than what is in the legislation.

The legislation calls for 2022. I think we'll be finished with most of this next year and we owe it to our veterans to get this commission rolling because of the issues that you've just raised.

Mr. ROE. Yeah. I mean, they may be absolutely needed. They might fit right in the niche exactly. But I don't want us to be sitting there having spent this money and then realize that we don't have any veterans to take care of.

So anyway I just wanted to know about that. So your suggestion would be to step up, as the market assessments are done in 2020 to go ahead and begin to assimilate the commission?

Secretary WILKIE. And, yes, sir. And as I said we have started the market assessments. Thirty one of the 96 that the legislation calls for are already underway. They're running concurrently across the country and I am very happy with their progress.

Mr. ROE. When will we have access to those so we can begin to get our arms around it on the Committee?

Secretary WILKIE. I don't know the answer to that. As soon as the information that I have I will share.

Mr. ROE. Okay. Thank you very much. I yield back.

The CHAIRMAN. Thank you, Dr. Roe. I now recognize Mr. Lamb for five minutes.

Mr. LAMB. Thank you, Mr. Chairman. Mr. Secretary, welcome back. Thank you for the budget proposal. I'm encouraged by a lot of the things that we saw in there.

When you were here for the VA 2030 hearing we talked a little bit about vacancies in the VA and you mentioned your priorities

were primary care, women's health, and mental health and I saw the increases in the budget for hiring full-time employees, student loan incentives, that kind of thing.

Is there a plan within VA to target those three specialities, or Dr. Stone if this is better for you, please go ahead? I was just kind of curious on the details of how we're going to go out and get those folks once we have the additional funding.

Dr. STONE. Congressman, yes. There is a plan to increase all of these. We have very active mini-residencies in women's services that we'll train another 600 providers, especially in our rural areas trying to get the right expertise into the remote areas of our delivery system.

For mental health we had committed over the last 15 months to hire 1,000 additional behavioral health providers. We've exceeded that and we'll continue to grow.

Within this budget there is the plan to grow our employment by another 13,000 individuals to ensure access. I'm quite pleased at the continued reduction in wait times across much of the delivery system. But we will progress on all of these fronts.

Mr. LAMB. Thank you. And I guess what I am asking you is how are you going to go and get them and get them to the places where we really need them? Is there a recruiting challenge or do you feel like with the additional money you can kind of just post the jobs, or what's the strategy there?

Dr. STONE. Hiring medical professionals and getting them into remote areas is a difficulty across all of American medicine but you've given us within the MISSION Act some great tools.

You've given us location specific pay. You've given us the ability to pay in enhanced amounts relocations. You've given us the ability to pay back student loans, and those are all proper areas and we appreciate those portions of the Act.

Mr. LAMB. Thank you.

Secretary WILKIE. And my view on that is in the next budget I believe I will be coming back to you and asking to make that program more robust. I've talked about a veteran's equivalent of the Peace Corps.

Mr. LAMB. I noticed that in your testimony.

Secretary WILKIE. And I think that's where Chairman Takano has been in the last few years, to get our young people back into rural areas in exchange for debt relief which this Committee championed in exchange for a specific period of service.

Mr. LAMB. Thank you. And I agree, we want to help legislatively. Please let us know besides the budget what we can do to help carry the ball on that.

Dr. Lawrence, sorry. Mr. Cisneros, could you lean back or something? Thank you.

Mr. LAMB. I have to say I know Dr. Roe characterized the appeals modernization process as a success so far and I think in a lot of ways on paper it might be. But I had a very troubling meeting with a lot of folks who are kind of on the front lines of this for us in Pittsburgh under VBA.

And they were called in. These are ordinary raters. They were called in on the Friday before this thing went live and told they needed all kind of new training and they needed to do things dif-

ferently, and they did not feel anywhere close to adequately prepared for the changes that came, again at the ground level.

So I don't know what the strategy was there, but can you explain why a significant number of your employees would have only been told that really the business day before this thing went live that they had to do things differently than they were doing before?

Dr. LAWRENCE. No, I really can't. I'll have to get behind that and maybe talk to you as to how that came about. The major processing of the appeals is done in Seattle and Tampa, so those are where we hired the 605 people you allocated for us. Some of the runoff is done in a couple of other places like that. I don't understand why that happened.

We had schedules that laid out several months in advance what was to take place, who was identified in the training they were provided. That's the anomaly but I'm happy to go and look and we can back to you on that.

Mr. LAMB. We'll follow up with you on that. I appreciate it. It definitely caused a distressed workforce. So I don't know if it was just a local decision to start doing things differently in advance of this or not. But I would appreciate it if you could look into that and maybe we could follow up on it.

Mr. Chairman, I yield back. Thank you.

The CHAIRMAN. I now recognize Dr. Dunn for five minutes.

Mr. DUNN. Thank you, Chairman Takano.

Secretary Wilkie, Dr. Stone, it is nice to see you again. Thank you for your time here today. I think we all know that there is a crushing shortage of GME residency slots in the country. The Choice Act authorized an additional 1,500. Can you tell me how many of those to date have been filled and what the uptake rate is on those?

Dr. STONE. I can't tell you exactly where we are. I know that we are at 123,000 residents that are training in our facilities. How many of ours, how many are part of our academic affiliates, I can break out for you and I will take that one for the record. I know that our goal was to grow over 1,000, but we will get that for you.

Mr. DUNN. I would appreciate the follow-up on that because I have to tell you, every single medical group that I speak to or comes in the office, that is among their first two or three questions, so I appreciate—

Dr. STONE. If I may, sir, let me add one other thing. We had 24 facilities that did not have teaching positions, especially in rural areas. In order to enhance rural attraction of physicians when they finish, 23 of those 24 are now online—

Mr. DUNN. Excellent news.

Dr. STONE [continued].—with residencies. And so, we just added that this year.

Mr. DUNN. Excellent, thank you very much.

Also, the President's budget acknowledges the administrative costs of implementing the MISSION Act's transplant authority for increased access. So, does that budget, does it include the estimated costs for a veteran seeking a transplant outside the VA transplant system? And also, does it include the costs for the new authority to pay for those who are having a donor, a living-donor transplant, and the donor is not a veteran?

Dr. STONE. It does, sir.

Mr. DUNN. Excellent, thank you.

And so, with this revised requested $2.862 billion, roughly, for implementing new access standards and the 2021 VA advanced appropriations of $4.583 billion, the money, in theory, will actually be appropriated well before the final roles on transplant authority will be finalized, which we expect in July of 2020. So, if we authorize the money for this purpose, is there still a delay in implementing the transplant policy or would you agree that we don't need to have a delay in implementing that policy?

Dr. STONE. Sir, we are still propagating the regulations. We are very hopeful that in the very near future, you will see those regulations and they will go out for comment. Following the comment, we will work our way through the rest of the process, including the comment from this body, that we will take. But we are very close with these, and I promised you that in a previous hearing. We are very close to having those out.

Mr. DUNN. You know how near and dear to my heart the transplant programs are. I look forward to working on that with you in the future.

Mr. Chairman, I yield back.

Dr. STONE. Thank you, sir.

The CHAIRMAN. Thank you, Dr. Dunn.

I now recognize Mr. Pappas for 5 minutes.

Mr. PAPPAS. Thank you, Chair Takano.

Thank you, Mr. Secretary, Dr. Stone, and the panel for joining us here today. I understand, Mr. Secretary, we may be seeing you later this month up in New Hampshire at the Manchester VA?

Secretary WILKIE. I will be up there in a few weeks, as a matter of fact.

Mr. PAPPAS. Excellent.

Secretary WILKIE. I am looking forward to it.

Mr. PAPPAS. Well, great. They are in a period of transition, but they are on the upswing and I think the volunteers, the veterans, the leadership, the staff, is certainly really eager to talk with you.

Secretary WILKIE. And I will add one thing about the wonderful reception that people in uniform get in New Hampshire. When I was the Under Secretary of Defense and prior to that, assistant secretary, the greeting that the people of New Hampshire provide to returning soldiers, sailors, airmen, Marines, at your airport in Manchester is probably the best in the country.

Mr. PAPPAS. Thank you. I will relay that message, and I don't doubt it.

I want to talk today about whistleblowers and the importance of them. It is a courageous act when someone at the VA brings forward information, complaints, or allegations regarding serious problems, wasteful and unsafe practices, even malfeasance. There is understandable fear that blowing the whistle could result in retaliation, including risk to the employee's job and livelihood. Whistleblowers represent a critical source of information about the VA and we must encourage people come forward.

I recognize that your budget proposal includes a four- and-a-half-million-dollar increase in the Office of Accountability and Whistleblower Protection. It is a good step forward, but I have some seri-

ous concerns about the office and how well it is performing. I have heard of shortcomings in meeting the needs of whistleblowers and whether they are protected from retaliation.

And, Mr. Secretary, I was curious if we have your commitment to an open and robust dialogue about the VA's support of whistleblowers and the strength and effectiveness of the Office of Accountability and Whistleblower Protection?

Secretary WILKIE. Absolutely. I had the pleasure of serving as the acting VA secretary for 8 weeks. One of the first visits I made was to the now-Chairman's office. Whistleblower protection was the first IT that he raised in that meeting.

I can say for the first time, we are requesting a direct appropriation for the Office of Accountability and Whistleblower Protection. We have, finally, a confirmed leader in place, someone known to the leadership of this Committee; she came off of the staff of this Committee.

In the last year, we have assessed about 2,400 whistleblower submission. We have 1,000 referred investigations in place. It is absolutely vital, particularly in an area as sensitive as veterans' care, that that office is as robust as possible.

Mr. PAPPAS. Well, thank you. And, Mr. Secretary, the budget that is appropriated, will that also result in more resources for responding to FOIA requests by whistleblowers?

Secretary WILKIE. Oh, yes.

Mr. PAPPAS. Thank you. And I will have my team follow up with your office at a later time to continue that discussion. I appreciate it.

Secretary Wilkie, your budget includes $107 million for the Department's Office of Inspector General, representing about a fifteen-million-dollar increase. The inspector general, the agency's independent watchdog, obviously plays a critical role in overseeing the operations of the VA, investigating instances of waste, fraud, and abuse. I applaud the increase.

I understand that the VA still has a lot of work to do in implementing many of the IG's recommendations; in fact, there are 557 recommendations that have yet to be addressed, including more than 140 that have remained unimplemented for more than a year, some for many years. Concerning the financial implications of not implementing recommendations, I am wondering if you can respond to this, and in addition to that, talk about your willingness to respond to the GAO high- risk list, which just recently added contracting to that list. Talk about your ability to implement and address these concerns.

Secretary WILKIE. Well, let me talk about the latter, first. And that is part of our response is modernizing the institution through business transformation. We are spending about $189 million or requesting $189 million on business transformation. Some of that is for IT funding. We have a 1960s- and 70s-business process system. That is why we are engaging in that reform, as well as supply chain.

As for the Office of Inspector General, that is why we requested additional monies, because we are doing so many things at one time. I would also say that we have an advantage that other departments don't have. We have really three law enforcement mech-

anisms. We have the Office of Accountability and Whistleblower, we have the IG, and we have the general counsel. There is a reason for that: Because no one else has the kind of mission that we have, and the results of us not doing our job can, at times, be catastrophic. So, that is why I put more emphasis on those arms.

Mr. PAPPAS. Thank you. We have got work to do.

I yield back, Mr. Chair.

The CHAIRMAN. I recognize Mr. Bost for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman.

Dr. Lawrence, I am going to go down probably the path that Mr. Lamb did, because I don't think that it is a localized issue. You know, we have been working really hard to ensure the new disability appeals system is implemented correctly. And I have recently been in contact with some of my constituents who are working to implement it and the concern that they have is they don't feel that the proper training is being done at the level and at the speed in which they need it to be able to implement the program.

Can you kind of explain to us what collaboration is taking place between the Appeals Management Office and Comp Services for training all of our employees.

Mr. LAWRENCE. Sure. So, first, I will follow up and try to understand that. This is important. Training on appeals modernization began more than 3 years ago with the understanding of what was new about the law and the different lanes it set in motion. About a year out, after working through the IT issues, began to identify the need for staffing and how we would actually process.

As I indicated, specialized centers were set up in St. Pete and Seattle for this reason; for this dedicated sorted of stuff. One lane would—it is a little complex—requires some work be distributed to around the regional offices. Some of those folks were to handle that other, what I call "runoff work" earlier. They were to get the training you are talking about. I don't understand how both, you and Mr. Lamb, described that, because the training schedules and the feedback that I received throughout was very, very positive about how it was done.

There is an element of learning going on. We appreciate that. There is an element of understanding by our team that we measure performance and they are naturally uncomfortable when that happens, but it wasn't designed—it was designed to provide training for this very purpose. So, I would be happy to follow up and better understand.

Mr. BOST. I hope you do. Believe me, I am one that understands old dog, new trick, okay, but these are pretty young people and they actually know their systems pretty well and it concerns me. And we want to make sure it works. Dr. Roe is right, I think it is a great process.

But that is going to lead me to my next question, and I don't know whether to ask the secretary or possibly you, Doctor. In 2020, the VA is projecting to complete 1.3 million disability-rating claims and the number of claims pending longer than 125 days will remain between 90 to 100,000 claims. My concern has been the legacy appeals, really.

So, can you please kind of explain how you intend to handle the legacy appeals and bring them online and get them to faster resolutions.

Mr. LAWRENCE. Sure. In terms of legacy appeals—I have had this conversation with Dr. Roe and his office about 6 or 8 months ago—we understand that it is important. So, as we shift to the new appeals modernization, we want to work off the legacy appeals we have; those before appeals modernization by the end of 2020. In our math, we have the dedicated staff to do that and it is our desire to get that down to, essentially, zero—a little bit north of zero because of some puts and takes on that next year.

The claims you talked about are traditional disability claims are the 1.3 to 4 million we process every year for what they are: disability claims. A couple of things are going in on that and that backlog is slowly creeping up and we have plans to deal with that. But it is sort of some simple math if I can share with you, right. The number of claims continues to go up every other year 3 to 4 percent. The number of folks we have working claims is essentially flat. We try to find some people and free them up and go do that. And the claims are getting more complex, more issues per claim. So, you see the math begin to work that way.

We are very concerned about rework and quality and we think that those are areas we could improve, which would enable the claims to process faster and bring those numbers down.

Mr. BOST. Like I said, I think it is a good program. I think we have to work the bugs out of it and speed up the process.

So, Mr. Secretary, I want to—also in my short period of time that I have left here— I recently introduced legislation that would require VA medical centers to do cost- benefit analysis of treating medical waste on-site. Now, I am asking for your support of it to bring the VA in line with the practices of CDC and world health organizations, because I think it would save us a lot of money. I think we are kind of behind the overall curve on implementing the waste disposal.

Are you familiar with what we are trying to get done?

Secretary WILKIE. I know the subject in general, and I will take a close look. I don't know if Dr. Stone has a medical response.

Dr. STONE. I agree with you, sir. I think it is time that we take a good, strong look at that, and we would support that.

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

The CHAIRMAN. I now recognize Mr. Brindisi for 5 minutes.

Mr. BRINDISI. Thank you, Mr. Chair.

Thank you, Secretary, for being here. Just an issue that is important in the district that I represent in New York state. The Albany VA Medical Center has proposed to move the Bainbridge CBOC, which is in the congressional district I represent, to a neighboring county.

Bainbridge and the surrounding Chenango County are extremely rural. Transportation and health care options are very limited, and the population is aging. Over 3,600 veterans reside in Chenango County and any potential move of the CBOC out of the Bainbridge area would have a tremendous impact on the veterans and their families in having access to VA care.

The Bainbridge clinic does not have a shortage of veterans utilizing its services; in fact, they are operating above capacity. So, if the VA does go through with moving the CBOC out of Bainbridge, as it is proposing, how will you make sure that veterans relying on the Bainbridge CBOC are able to access reasonable care and health after moving the clinic?

Secretary WILKIE. Congressman, I am familiar with this issue, and this clinic really draws from 3 counties. One of the difficulties we have in the current location is a lack of public transportation, and many of our veterans need help getting there. So, we considered moving about 20 miles away to an area that does have public transportation.

The lease on this facility that they are in, they have outgrown the footprint. We got some issues for women veterans in privacy in the current structure there. We have also got some issues in the surrounding buildings on this, as far as the safety of the area.

So, our lease is up in 2021. We are just in the early process of looking. This came to my attention been the last month. We are taking another look at it and would be happy to engage your office in that discussion. Especially because of the rural nature of this, we do have the need to be able to accommodate another PAC team at that site and we don't feel that specific facility will accommodate it. But whether we could accommodate a closer location than going all the way to the hub of the area where public transportation is, I think, is an open discussion and I will more than willing to have it with you.

Mr. BRINDISI. I would like to have that discussion, because I think the county that you would be moving from, that is where the public transportation options are very limited. So, getting the veterans from that rural area into a more populated area is going to be very difficult for them to get there.

The other issue that I was pleased to hear the secretary say that he is a vocal proponent of market-area assessments, which I think is a great thing and certainly a requirement under the VA MISSION Act. As I understand it, there is not a market-area assessment that is going to take place until at least 2020 in this region. So, why move forward with moving the CBOC until you do that market-area assessment to determine the needs of that community?

Dr. STONE. I understand, and I am in full agreement with the secretary on the market-area assessments. Please remember, though, that the lease on this facility is not up until 2021, so we would be through a market-area assessment before we decided on that move.

Mr. BRINDISI. Okay. So, I can get a commitment from you today that you are not moving the CBOC until at least 2021?

Dr. STONE. Unless I am substantially misunderstanding this issue, and I would be more than happy to engage after the hearing in this one to make sure that I have got the dates right.

Mr. BRINDISI. Okay. I would love to follow up with you after.

And just second, I was pleased to read in the secretary's testimony that the VA remains committed to investing in the National Cemetery Administration's infrastructure, including constructing new cemeteries. As you know, one of the NCA goals is to provide

access to a national or VA-funded state cemetery within 75 miles of a veteran's residence. And I read in your testimony that following completion of planned expansion projects, nearly 95 percent of veterans will have access to these burial options. I think this is great progress, but unfortunately, the veterans from the district that I represent would still be part of that 5 percent that is still lacking access to a national cemetery. The closest cemetery to our district is over 90 miles away in Albany, New York.

So, I just would encourage you to look at that and ensure that we can close the gap certainly in those areas that are a little more rural and a little further away from some of the national cemeteries.

Secretary WILKIE. Yes, sir, absolutely. And I understand that the Under Secretary for memorial affairs, Randy Reeves is either visiting with you or your staff to discuss the way forward. I also encourage Secretary Reeves across the country, to make sure that we also interact with states in terms of us getting grants to the state so that state-veteran cemeteries are made whole. But he will have a way forward for you when he meets with you.

Mr. BRINDISI. Thank you so much, Secretary.

I yield back, Mr. Chairman.

The CHAIRMAN. I now recognize Ms. Radewagen for 5 minutes.

Ms. RADEWAGEN. Thank you, Chairman Takano, and Ranking Member Dr. Roe for today's hearing.

Thank you to Secretary Wilkie and the rest of VA for coming. It is always a pleasure to see you, and I also want to welcome the VSOs and thank them for their input today.

Mr. Secretary, one of the provisions of the MISSION Act included an assessment of health care furnished by the Department to veterans who live in the territories of the United States. The report determined that VA furnished health care in the territories overall and it is considered both, sufficient and efficient, but also projected an increase in demand for services and noted that veterans in the U.S. territories have to travel to Hawaii or the mainland for much of their care.

The report seemed optimistic about the VA's ability to handle health care needs of the territories through the use of Community Care to provide services closer to home. The report cites projections of our territory veterans' demands for care across 10 to 20 years. Does this same sort of foresight apply to this budget proposal? And could you please go over, briefly, the VA's short-term and long-term plans to meet the needs of the territories and remote areas.

Secretary WILKIE. I have been very, very open about my desire to serve those communities in the country, in our rural areas, and in our territories, particularly in the Native American communities and the native communities of the Pacific.

One of the reasons I have stated is that no group of Americans serves in higher number than those Americans, and no group of Americans has more medals of honor per capita than the Americans that you represent. I will be headed to the territories at the end of May.

In the short term, our budget for telehealth is the quickest way that we can respond to the needs of diverse populations, not only in your area of the Pacific, but also in places like Alaska. By get-

ting our VA doctors to service those veterans in your area, across jurisdictional lines, state lines, in addition to doing as much as we can to make more robust the clinics that we have in the territories.

We are not going to be able to give you a 100 percent answer that 100 percent of the health delivery—health services that we provide will be available to all the territories, but it is something that we are working diligently on. And I do think that telehealth is the most important investment that we can make right now to make a difference.

Ms. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you. And now I will recognize Ms. Rice for 5 minutes.

Ms. RICE. Thank you, Mr. Chairman. Secretary Wilkie, in response to the IG report that found millions of dollars in GI bill benefits going to for profit colleges that violated VA standards, what steps have you at the VA taken to address this issue and where are you in the process of implementing the IG's recommendations?

Secretary WILKIE. I would say before Dr. Lawrence answers, I do want to respond to something that the Chairman said. It is our policy when these institutions that you described fail to make our veterans whole, they will not be penalized when an organization goes out of business.

Dr. Lawrence can talk about some of the hurdles that we have under the law, dealing with state accrediting agencies. I think that is a topic for another hearing. But I did, before he answers, want to make sure that veterans who find themselves in those situations, we will make whole again.

Mr. LAWRENCE. Sure. We agreed with the report. And we began expeditiously to implement the recommendations almost immediately. Perhaps the most thing that had the direct effect was in the fall when we renegotiated our contracts with the state approving agencies, we put in more of the teeth they suggested we do to get them to make some of the things we requested of them not so optional, that they would go and do it. But we are implementing those recommendations. Most of them were to take place over a year and we are on track to have them all done.

Ms. RICE. Secretary Wilkie, do you support closing the 9010 loophole?

Secretary WILKIE. I support institutions—let me, I will confess I am not an expert on that matter. I support institutions that serve students. And yes, I will say something that is probably against interest, I agree with the Chairman's view that institutions that are primarily dependent on Federal students and students who bring to those institutions' Federal money, they need to be looked at carefully.

Ms. RICE. So have you spoken personally with Betsy DeVos about ways to address this issue?

Secretary WILKIE. I actually have spoken with her. We have had one meeting on it.

Ms. RICE. And can you expound on that?

Secretary WILKIE. And I shared my concerns.

Ms. RICE. So I want to talk about women veterans, in order to ensure that they are included in VA health care and benefits. We often concentrate solely on health care, but there are other non-

health care related issues that affect women veterans, which includes access to benefits. Now, you have testified to this Committee now on more than one occasion that the VA is working to increase the trust of women veterans in the VA, so they choose the VA for benefits and services. However, there still remain cultural barriers women veterans face at many, not all, but many, VA facilities. And it continues to be a significant deterrent for women in terms of accessing VA benefits.

You have got the issue of sexual harassment, which remains a major problem at VA facilities, and for the roughly 30 percent of women veterans who have reported being harassed or assaulted while serving in the military, and for those specifically seeking treatment from the VA for military sexual trauma, this type of environment isn't only an impediment to accessing VA benefits, it can be traumatic. Beyond that, women veterans continue to say they are made to feel like they don't belong at the VA, often citing situations where VA employees assume, they are a veteran's spouse, rather than a veteran or combat veteran themselves.

Now, you and I disagree on the VA motto. And I am going to ask you to please reconsider your position. Because it is not just what you do internally once a woman begins to wear the uniform of this great country of ours, which over 2 million women have, but it is what you say and what you hold out as the motto of this great agency that speaks to women about how they are going to be respected within the VA. So do you—

Secretary WILKIE. Well, let—

Ms. RICE. So do you consider changing the culture at VA to be one of the department's goals under your leadership, and how are you working to address the cultural barriers that have inhibited women veterans from accessing services at the VA?

Secretary WILKIE. Let me take a step back and talk about my record and then the change in culture. But I will first say that those same VA satisfaction reports that I mentioned at the beginning of my testimony, 84 percent of all women veterans who use VA trust the VA and they are very satisfied with the VA.

As the Under Secretary of Defense and some of the members have been on the Armed Services Committee, my first directive was to give the Department of Defense its first comprehensive sexual harassment and equal opportunity policy. I am the son of a combat soldier. My father spent most of his career in the 82nd Airborne Division. It was unthinkable as a child that I would see an American woman wearing the red beret of the All-American division. It is not unthinkable anymore because of the changes in the military culture.

VA has moved to change with that culture. The young Americans who serve today are not the veterans who served with my father in Vietnam. We have a diverse and integrated military, and those changes are bleeding over into VA. It is my goal to make sure that our VA is as welcoming as possible, and I talked a little bit about that in the last hearing. But I am very happy that for the first time, I can tell you that the satisfaction rates for American women using the VA are at an all-time high and they are getting better. 500,000 women had VA appointments last year.

In terms of the budget, about 10 percent of the budget that we spend on medical care go to American women. That represents 10 percent of the veterans' population. So we are moving. Our people are being trained. Certainly if we find any problems, we address them right away.

Ms. RICE. I just ask you, when we talk about all these issues and modernization, you cannot leave women out of that modernization.

Secretary WILKIE. Absolutely not.

Ms. RICE. Thank you, Mr. Chairman.

Secretary WILKIE. Absolutely not.

The CHAIRMAN. I now recognize Mr. Bilirakis for five minutes. Mr. Bergman, General Bergman.

Mr. BERGMAN. Thank you, Mr. Chairman. Every budget cycle, we have been giving the VA more money because we are not only hopeful, but we are optimistic that you are going to provide better outcomes, you know, with that money. One of the challenges that we have all—we have had hearings on is the appeals process. And I have got an appeal here dated March 22nd, 2019, in which basically the word remanded is used in six different instances. Okay, so one more time back through the loop.

And this—my constituent caseworkers have been working on this for a while, working with an 85-year-old veteran, 9-year-old Legacy, one more time just recently remanded by the Board of Veterans Appeals. Unfortunately, and it has been remanded multiple times. Unfortunately, the VA regional office erred by not complying with the Board's previous remand order, which further prolonged—you know, you see the scenario I am building here.

As the VA updates and modernizes the appeals process, what improvements—I mean, really, what improvements are we going to make so that we can—I mean, maybe—hopefully this is just an outlier, but we talk about the numbers of, I was going to say back orders, but backlog, if you will, on the timeliness issue. How are we going to improve the accountability, the timeliness, especially when errors occur of our own doing? If we kick the ball in the stands, do we have a way to bump it up in priority saying because this 85-year-old is not getting any younger. And we owe it to them.

Secretary WILKIE. So I will let Dr. Lawrence get into the particulars, but let me tell you where we are. We have the largest budget request in the history of the appeals process. That is to sustain about 1,500 full time people handling appeals. We will achieve the largest number of appeals ever processed by VA this year, over 90,000. But this is not immune to the modernization efforts that we have under way. There are too many appeals that start with the hand processing of those appeals.

So my directive is to modernize and have an IT system in place so that the triaging is rapid, that we don't have somebody who sits at a desk and processes 10 appeals a day, a request manually. That that process is modernized, and it is made efficient and relevant to the 21st century.

Mr. LAWRENCE. Let me comment without going too much into the weeds, sir. But part of what you are seeing is an outlier, but it is not unusual. Part of what happens, which led to appeal modernization, is a case made its way to appeal. And while it was waiting, the reasons why the veteran was asking for help changed. And so

when it came time to deal with the claim, the reasons that changed, and they would send it back and say, "We now need more information." The condition has gotten worse and this doesn't reflect that. That led to appeals modernization in part because it was designed to sort of have these lanes, which could deal with things.

Thing one would be a higher level of review. A math mistake was made, can you correct it? A more senior person could look at that and deal with that right away. Additional evidence is needed, but it can be done quickly. Each of those two lanes will hopefully enable the appeal to be resolved quickly so it doesn't linger and require the looping back and forth that you described. I am happy to learn more about that and look in on and see if we can't figure out why it is going back.

Mr. BERGMAN. Thank you. And we are dealing with exceptions here and not the rule, but the question is how do you—we have to have a way. And just one quick last question because I see my time is getting short. And this is a yes or no answer. The current budget funds an increase of over 13,000 positions, you know, within the Veterans Health Administration. Is there a TO, table of organization, that we could look at that shows those 13,000 openings so you know exactly when we hire them, we have got a place to put them?

Dr. STONE. The answer is we are getting closer and it is not as simple as yes or no.

Mr. BERGMAN. As you got one, I would certainly like to see it.

Dr. STONE. It is not like you were used to in the Department of Defense.

Mr. BERGMAN. Okay. Well, we like those tables of organization to give an idea.

Secretary WILKIE. Mr. Chairman, may I give a more complete answer to that?

The CHAIRMAN. Proceed.

Secretary WILKIE. Thank you for your indulgence. You just hit it. We are used to more complete table of organization in the Department of Defense. I have used this description before in testimony. I don't know that I have used it in the House. My first week as secretary, I asked two different senior leaders for the number of employees that we had. I got two different answers.

And then I asked for a manning document, which you know is the table of requirements and the people needed to meet them. We never had one. We now have a modern sophisticated HR team in place, some of whom coming on were senior leaders in the A–1 of the Air Force. One is already on board. Another is coming. They are going to get that manning document and we are going to—we will put in place the type of HR system that you are used to in your military career, I am used to, the people at this table are used to.

Again, that is part of the overhaul of a department that I think if General Bradley walked into it a year ago, he would probably recognize a lot of the processes.

The CHAIRMAN. Now, I will recognize Mr. Cisneros for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman. Thank you, gentlemen, for being here this afternoon. Mr. Secretary, I just want to follow up really quickly on Ms. Rice's question about the GI bill and your statement about making the veterans whole.

My hope would be that when they would—that these veterans that were at these schools that have been closed, they would be able to transfer their credits to an accreditable university. But in cases where the existing credits cannot transfer or the school closed mid-semester, that the veteran would hopefully receive their tuition back, receive their VA stipend back. That is my definition of whole. What would be your definition of whole?

Mr. LAWRENCE. We are very similar. So when schools are closed, we then reach out to the students and figure out exactly how we restore eligibility. As part of the Forever GI bill, that is the new benefit exactly as you said. You don't lose the months. You continue on a new process. So we restore months of eligibility when this happens.

Mr. CISNEROS. That would be a student who is maybe going to school, been there three years already, used maybe about 24—we'll say 24 months of his eligibility, school closes. Would he be able to get all 24 months back?

Mr. LAWRENCE. Perhaps. But also, he would hopefully transfer credits and only needs a limited number of those. So everything is case specific. But that is the intention to not penalize them the way you are describing for the school's behavior.

Mr. CISNEROS. Secondly, I want to talk about vocational rehabilitation employment program. I had a veteran's roundtable recently in my district and a lot of the veterans that we sat down and spoke with were saying that they were constantly shifted counselors. They would tell them their story. They would get a counselor and explain their situation. And then next time, it was a whole different counselor and they would have to start the process all over again.

To that end, I understand that in 2016, Congress passed into law a requirement that the VA must ensure a ratio of 125 veterans to every 1 voc. rehab counselor. And I also understand that the VA is moving 127 of those counselors out of those positions and into full time positions for support and management. How are we going to hire more people and how are we going to fill those positions to ensure that the veterans, that we are keeping the proper ratio?

Mr. LAWRENCE. I was confirmed about a year ago. And in preparation for that confirmation, I learned about the law, the 1 to 125 and realized we were out of balance. One of the first things that happened when I came onto the job, when I was confirmed, is to begin executing a plan of hiring counselors to deal with exactly that. We are in the process of hiring to meet that number and hope to have it done shortly. We had to hire a couple hundred through the process.

In addition, we had to reallocate. I don't know about the moving amount of management positions because that would work against the intent to meet the ratio. I will tell you that we had some misallocation of those that I inherited in the wrong place. Also we had some of the wrong people in the jobs, and we had some of the churn you are describing. So we are in the process of not only hiring, but reallocating to make sure that doesn't happen the way you are describing. But it is our intent to fund and support the voc. rehab program directly and consistent with the law.

Mr. CISNEROS. So when do we think we will have a timeline of when that will be fully?

Mr. LAWRENCE. I am tempted to tell you a date off the top of my head, but it will be wrong. There are little puts and takes as some people were recruited away from us. So shortly and I will be happy to get back to you with the exact date.

Mr. CISNEROS. So currently, you are going to spend about $60 million in overtime for these counselors. You are only asking for about $35 million from the 2020 budget. So can we expect maybe that is because you are going to have the number hired by 2020? You think you will be fully manned by 2020 or is it going to go beyond that?

Mr. LAWRENCE. Let's separate two issues. I think the overtime request we are making is for more broadly all of VBA, not just the counselors, sir. But the answer is yes. We are going to have them hired in fiscal year 2019. I don't want to give you a date to be off by a couple of weeks, but I am going to give you a date that precisely shows you when we are going to meet the ratio.

Mr. CISNEROS. So you are saying—I will take 2019. By the end of fiscal year 2019, you are saying we will be fully manned? We will have enough counselors to me the 1—

Mr. LAWRENCE. Not only that, I will come to your office on the day it is, and we will count the days between the end of the fiscal year to see how many there are.

Mr. CISNEROS. All right. I will hold you to that.

Mr. LAWRENCE. I will be happy to come and talk to you about voc. rehab then, sir.

Mr. CISNEROS. I yield back my time.

The CHAIRMAN. I recognize Mr. Barr for 5 minutes.

Mr. BARR. Thank you, Mr. Chairman. And gentlemen, then you for your service in uniform, and thank you for your service today to our veterans.

Mr. Secretary, this budget request provides $15.3 billion for medical community care. You are asking for a $2.9 billion appropriation to roll out the access standards for the program. Obviously, you see that there is a need for veterans to be able to access care in our own community, yet this funding is not going to be effective if there is a lack of quality providers in the community who choose not to participate in the community care program.

Are we funding the MISSION community care program in a way that supports provider reimbursement and in a way that attracts quality providers and makes the program work? And Dr. Stone, you can answer that question as well.

Dr. STONE. Congressman, I think the only way you retain providers to any delivery network is to pay him in a timely manner and treat him respectfully. So therefore, the community care contracts, the first of which in Region 1 where we are beginning to implement is in full partnership with the provider networks. We continue to stress timely payment. I am quite pleased that in the month of March, we paid over 1.7 million claims in less than 30 days. That in comparison to a year ago was at 140,000 in a month.

We anticipate going over 2.3 million claims paid in the month of April as we continue to progress through this. But retaining good community providers at high quality institutions will only be effec-

tive if we can treat them respectfully and pay them in a timely manner.

Mr. BARR. I fully agree with that. And the community care program is certainly something that the veterans that I represent are clamoring for, but they obviously—it won't be effective if we don't not only timely reimburse, but adequately reimburse to attract quality specialists to the program. And on that point, Mr. Secretary, if the requested budget were to be enacted as requested, it looks like 19.2 percent of the VA's medical care dollars would be allocated to community care while 80.8 percent would be allocated to care provided in VA medical facilities.

Given the plan's streamlining of community care options for veterans alongside the funding to strengthen VA medical care, do you feel that this 80/20 split is accurate or about right in terms of meeting the needs of how veterans will seek care?

Secretary WILKIE. I think it is about right, based on what I have seen in terms of patterns of our veterans in terms of the care that they seek. The other thing that I would add to that is it is adequate because the MISSION Act is not full choice. The MISSION Act applies only when we cannot provide the veteran a particular medical service within a specific amount of time. Based on the numbers that I have seen, that is not going to be a regular occurrence for most of our veterans.

Mr. BARR. No, I understand that. And so your assessment is that that 80/20 split is in line with the share of veterans actually seeking care within the VA versus within the community?

Dr. STONE. Congressman, let me give a little more detail. In 2017, we purchased 32.5 million visits in the community. In 2018, that dropped by about 2 million to 30,500,000. In addition, this year, in the first six months of this fiscal year, the direct care system, the VA itself, has grown by over a million visits and over 100,000 additional veterans have come to us and enrolled in care.

So we think the split is about right.

Mr. BARR. Okay. Thank you. Final question, Mr. Secretary. I want to ask you about how the VA disburses compensation payments for disabilities, specifically sleep apnea. A 2018 VA annual benefits report listed sleep apnea as one of the most prevalent service-connected disabilities triggering VA compensation benefits. It is my understanding, however, that the VA does not track to make sure veterans are actually complying with treatments as a condition of receiving benefits. Meaning that the VA could be expending resources that may not actually be helping veterans.

How much does the VA spend on treating sleep apnea, and how does the VA monitor benefit awards to make sure that those receiving compensation benefits are actually getting helped with treatment?

Dr. STONE. So CPAP machines are our greatest prosthetic, our largest prosthetic that we purchase, and I can get you the exact number on that. We are actually progressing very nicely with a national contract for that in order to control cost. But the second thing is how do we monitor compliance with therapy. And it is my understanding, and I am going to correct this. We were talking about this in the last 24 hours. It is my understanding that the current devices actually have a monitoring device that then can be

monitored during a physician visit to monitor compliance with the use of the device. But let me confirm that and bring it back to you, sir, and make sure that we have got it. But that is my understanding.

Mr. BARR. That would be great. My time has expired, but obviously we want the veterans to get the help that they need as we help them with that. I yield back.

The CHAIRMAN. Ms. Lee is recognized for 5 minutes.

Ms. LEE. Thank you, Mr. Chairman. Thank all of you for being here and for your service to our country's veterans. I want to reiterate and touch on what Congresswoman Brownley briefly discussed regarding our Subcommittee meeting yesterday, where the GAO continues to see governance issues as a problem for the implementation of the EHRM.

We are coming up on almost a year from when the GAO first testified and proposed a governance structure that would be expected to leverage the existing joint governance and suggested the IPO, the inter-agency program office. And then in September, the VA, you all then concurred with that recommendation and stated that the Joint Executive Committee, a joint governance body between the DoD and VA had approved the role for the IPO.

But we do not yet have this inter-agency program office plan, this Committee, and the Subcommittee doesn't have this either. So Mr. Secretary, when you were before the Senate a couple weeks ago, you were not able to provide a timeline then for this office. Are you able today to tell us what plan you have?

Dr. STONE. Congresswoman, the inter-agency program office, we continue to discuss with DoD. As you know, because of substantial oversight, we are working our way through, trying to make sure we are complying with what everybody wants and we are sharing with you openly how we are proceeding, and that we are giving you appropriate chance to give oversight.

So that said, we have a couple of big problems as we approach this implementation. Number one, the common technology platform, and secondly, the cybersecurity of this as we move into the DoD enclave. We need more rapid decisions. And if we are going to deliver potential advantage to the American taxpayer based on efficiencies, we need to make these decisions quickly together.

We are in active consultation. I had a discussion Friday with the acting Secretary of Defense for health about this as we try to decide leadership and move our way through. But there are lots of emerging interests as we work our way through this very difficult process. But we owe you a common platform of leadership that delivers the efficiencies that you expect.

Ms. LEE. Thank you and thank you, Secretary. I know you understand the importance of having this leadership role well defined. We have heard that the DoD might leave this office and I just wanted to—which causes concern, given that this is supposed to be a joint effort and it is true that the VA has a bigger investment in terms of dollars and in people. What is your view on leadership of the IPO and how will you ensure that the VA's equities are just as represented as DoD's?

Dr. STONE. What we would really like is the best person in the place, regardless of their background. We want somebody that fully

understands both departments, fully understands the complexity of these departments. So I would say that first, we want the best person. And we want that person to understand both departments.

I think in addition to that, finding the interim leadership that can lead us through some decisions in the next 6 months is essential. We do believe that this should move beyond the acquisition community, which leads both areas today and move to the end technical user. And so you should look for a leader that understands the end technical and clinical components of what we are trying to implement.

Secretary WILKIE. And I would say that has been my emphasis. I have the advantage of having led both organizations. Led defense health, now leading VA. I would be lying if I said that the Department of Defense was a less than complex organization with a less than complex bureaucracy because they deal in the most massive expenditures of government money in our experience. They tend to look at things as acquisition.

I am not going to be satisfied unless we have what we now call a purple person, a joint person, who understands Dr. Stone's world and understands the world of the patient. That really is my bottom line.

Ms. LEE. Great. Thank you. Appreciate that. I yield.

The CHAIRMAN. I recognize Mr. Meuser for 5 minutes.

Mr. MEUSER. Thank you, Mr. Chairman. Thank you, Dr. Roe. And thank you, all of you, and Secretary Wilkie, very nice seeing you again. Appreciate you making the time to join us this afternoon.

I would like to begin by thanking the president and the Department of Veterans Affairs for their budget proposal. I truly can't think of many tasks more important than ensuring our veterans and the VAs have the resources they need to serve those who have served our Nation. I recently toured the Wilkes-Barre VA, met with the director, Russell Lloyd, had the great opportunity to meet with many of the veterans that utilize the Wilkes-Barre VA. And I also had the chance last week to meet again with Director Bob Callahan with the Lebanon VA, who do a terrific job for the veterans in the 9th District.

I have heard from many, I attended a Vietnam veterans celebration last week, and I heard many challenges from them, of course, and successes, and problems that they may be having, but I am very encouraged by the proposal set forth by the department to do the best job for the veterans as possible.

This budget proposal does invest in our Nation's VAs, especially with regard to the implementation of the MISSION Act, to help ensure that the men and women who fought for our country, again, and defended our freedoms received the timely, high quality care they deserve.

So my first question is to Mr. Secretary, the 2020 budget request is $220 billion; does it, in fact, fulfill the promises made in the MISSION Act? Will it allow you to carry out the goals of the MISSION Act?

Secretary WILKIE. Yes. And it does so by recognizing the fundamental change that is made evident actually in the title of the legislation, integrated service, where veterans now will be part of a

nationwide, integrated health care system, with VA at the apex, and we will be able to access for them, when needed, care in the community when it is called for.

I think this budget is the first important step, but it is a step that goes beyond MISSION, that includes the fundamental reform of the entire way we do business; everything from as Congresswoman Lee said, the electronic health record, to business transformation, to HR transformation, and to supply chain transformation, which is all included in the budget.

Mr. MEUSER. Sure. All right, excellent. Very happy to hear that. I do represent a part of Pennsylvania that is relatively rural. Can you speak about the investments made to help veterans in such rural communities?

Secretary WILKIE. Absolutely. And I have said, I think the most important part of this is to create that balance that takes cognizant of the fact that almost half of our veterans live in rural areas of this Nation and in the territories. One of the things this budget calls for is the expansion of telehealth. Tele-health allows us to reach into communities that in many instances we have not been able to reach. It is on the cutting edge of mental health services.

The other part of this is, as Dr. Stone said earlier, making it easier for us to get medical professionals into rural areas by using the tools in the MISSION Act: loan forgiveness, relocation pay. We are able, thanks to the legislation, to provide compensation that is outside of the usual OPM buckets.

Mr. MEUSER. Well, thank you. There are certainly many veterans counting on your work. Thank you very much for your service, and please continue to notify us as to how we can help.

Secretary WILKIE. Thank you, sir.

Mr. MEUSER. Chairman, thank you. I yield back.

The CHAIRMAN. I am going to recognize Ms. Rice for one minute to ask a question, since she was kind enough to yield her time to the secretary to answer a question.

Ms. RICE. Thank you, Mr. Chairman. First, Mr. Secretary, I want to thank you for supporting closing the 9010 loophole, number one. And number two, I have a question about a concern that is based on the VA's challenges with the development of a medical surgical supply formula that looking to DoD to solve these supply chain challenges may be a mistake, given the fact that the DoD has a well-documented history of medical supply chain challenges, which is why we have asked GAO to review this pilot program. If you could just answer the question, why did the VA choose DoD's model?

Dr. STONE. This is a deeply fractured supply chain within the VA, one in which it is very difficult to assess where we are at and where we are not. And the secretary has spoken extensively in previous testimony about the use of credit cards in our system.

There are two pieces of this decision. One is the use of DMLSS as a software system. The second is the potential use of DLA as a potential supplier of medical supplies. We have not made a final decision on the use of the defense logistics agency, and won't until we break the code in mid- May in North Chicago. That final decision will not be made until we go through the IOC sites in Spokane and Seattle and can demonstrate and share with you the actual fi-

nancial implications of this. And this comes back to the previous questions on how will you fund this.

I think there is a lot more data that has to be tackled, but I think it is worth a good try. Secondly, you have to recognize that all of us grew up with the defense supply chain in combat, experienced the defense supply chain's ability to get material—medical materials to us anywhere in the world. And so we are deeply respectful of it and look forward to its ability to potentially meet all of the additional requirements that we live with under, including—in our preferred small businesses.

Secretary WILKIE. And I would add, what we have is not working. And Dr. Stone mentioned something that I said when I appeared in front of the Committee in December. Last year, there were almost 4 million individual credit card transactions, buying everything from boxes of tongue depressors to radiological equipment. That is a system not only ripe with inefficiencies, but I believe is ripe for potential corruption. And getting to the heart of this is the only way I believe that we can provide veterans with the stability that they deserve when it comes to their VA facilities having equipment ready and able to meet their needs.

Ms. RICE. Thank you.

The CHAIRMAN. I know recognize Mr. Levin for 5 minutes.

Mr. LEVIN. Thank you Chair Takano for holding this hearing. I would also like to thank Secretary Wilkie and his team, as well as the representatives from our key VSOs, who are joining us today. I have the great opportunity to be the Chairman of the Economic Opportunities Subcommittee, so I would like to focus today on the issues of veteran homelessness, education, and employment.

Mr. Secretary, I appreciate your comprehensive overview you provided to us. I did notice that your budget request only provides level funding for homelessness programs. And while I understand that the number of homeless veterans nationwide has dropped over the last decade, as we discussed last time you were here, it is obviously a very big issue in Southern California where I represent. During the VA 2030 hearing, you said, and I quote, "If we got a handle on homelessness in Southern California, the number of homeless veterans in this country would reduce exponentially. That is the epicenter." And unfortunately, that is, as you know, that is an accurate statement.

We had the 2018 point in time count recently and it found that nearly 29 percent of our Nation's homeless veterans are located in California. So it stands to reason that the resources should be directed accordingly, but that is not always the case. For example, in fiscal year 2019, our state only received 18 percent of funding under Supportive Services for Veteran Families.

So my question for you, Mr. Secretary, can you tell me how the department plans to ensure that the requested $1.8 billion targets the geographic areas that need it the most?

Secretary WILKIE. Well, it is my intention and my directive that we go to the heart of the matter. There is a good news story. A few years ago, there were 700,000—let's say almost 700,000 veterans experiencing homelessness at any time of the year. That is down to about 40,000 now. As you mentioned, primarily on the west coast and in Hawaii.

What we have been able to do is use HUD and some of our partners to address the immediate needs of those who are homeless. It is a good news story in that we have over 60 communities in this country who have effectively ended veterans' homelessness. I will speak to Southern California.

Before he left office, I had conversations with Governor Brown. I have had conversations with Mayor Garcetti. The only way we are going to get a handle on this is to increase the amount of money flowing to the states and localities to help us find those homeless veterans.

I will say emotionally, one of the saddest sights that I have seen in my professional life and in my time being around the military is West Los Angeles at night when veterans come in in their cars, and they have jobs, but they have no place to live.

I talked to the Mayor about establishing more transitional homeless housing for them. I have asked HUD to increase the number of vouchers. But I am also looking at ways, big cities like New Orleans, and smaller cities like Abilene, Texas, have been able to eliminate homelessness by engaging what properly called NGOs. As I said, 64 communities, 3 states have eliminated homelessness.

So it is not a VA specific issue. It is one that requires more close cooperation with the states and localities, as well as HUD, and some of the other agencies.

Mr. LEVIN. Sir, obviously our Subcommittee would love to follow up and work with you on that.

Another question for you, during the 2030 hearing again, we discussed your commitment to implement Sections 107 and 501 of the Forever GI Bill by Spring 2020, while simultaneously correcting claims retroactive to August of 2018. And you said then that you didn't envision any new staff needing to be hired due to improvements under the new IT system.

I noticed this budget actually cuts education by $30 million and 45 full time employees. So how do you plan to transition to this new system and implement the Forever GI bill with fewer resources? And have you planned for the possibility that technological glitches may occur, which would actually increase staff workloads?

Mr. LAWRENCE. Sure. A couple things. Our plan is to implement in Spring 2020 as we have indicated. We have been working this very closely. We are on track to do that. Our intention is to do so. One of the things the new plan will have is increased automation, making those few people unnecessary and the savings accordingly. We are on track to do that. Worst case scenario is we will continue to process it as we have been, and we executed the spring of this year on schedule. So positive news there for that. Everything is positive going forward. We think we are going to meet that, and we talk regularly to your staff once a month about the status of where we are, what we are doing, and how it is going.

Mr. LEVIN. I am over time, Mr. Chair, but I appreciate your answers. Thank you.

The CHAIRMAN. I now recognize Ms. Luria for 5 minutes.

Ms. LURIA. Thank you, again, Secretary, for appearing before our Committee, and I wanted to thank you for your recommendations against an appeal of Procopio. As you know, Blue Water Navy vet-

erans have waited decades to receive benefits for diseases related to herbicide exposure during their service in the Republic of Vietnam.

Dr. STONE. Particularly on Hampton Roads.

Ms. LURIA. Yes.

Secretary WILKIE. And in light of that, I wanted to follow up on my question from our hearing in February regarding VA health care benefits for Blue Water veterans. At that time, I asked you if you plan to treat Blue Water veterans as eligible for Priority Group 6 health care benefits based on service in Vietnam.

I was wondering if you have an update on that now.

Dr. STONE. I believe that is our intention, but let me confirm that for sure.

Ms. LURIA. Okay. And I will submit for the record, as well, a follow-up letter that I sent on April 1st also requesting the information from the previous hearing.

Ms. LURIA. On the note of that with the Blue Water veterans, have you estimated the additional full-time equivalents or additional costs or additional personnel that you will need in order to process these claims for Blue Water veterans?

Secretary WILKIE. Before Dr. Lawrence talks, I will say what I have said to departments of our Federal Government and to some VSOs: We are just beginning to get our hands around the issue in the sense that part of our process will involve being historical detectives. The Navy in the Vietnam era had no standard policy when it came to report service in the waters off of Southeast Asia.

I will give you an example. You might have a destroyer captain who gives all of the members of his crew a service ribbon for time in those waters.

Ms. LURIA. Are the deck logs of all of our ships not available through the Navy?

Secretary WILKIE. Many have deteriorated.

Ms. LURIA. Okay.

Secretary WILKIE. And then the carrier that it is serving with 6,000 sailors doesn't have that ribbon. I have looked at some of these records and they fall apart.

Ms. LURIA. So, I understand the complexity. And do you acknowledge that it will take additional resources to do this analysis?

Secretary WILKIE. Yes, and we will look to that.

Ms. LURIA. Okay. Thank you.

Secretary WILKIE. I think Dr. Lawrence had a comment.

Ms. LURIA. No, I would like to just move on in the limited time I have left. So, looking at the budget, and I will just reference the page, VBA 57, it gave a table of veteran compensation by degree of disability. And so, I went through this table between 2012 and 2018 and I noticed that during that six-year timeframe, there was an increase in 1.2 million veterans, about 200,000 a year, or a 35 percent increase during that timeframe.

And then I broke it down a different way to look at both, the number of veterans over 50 percent as well as the number of veterans at 100 percent disability. So, in the over-50 percent category, that went up by 11.8 percent in the six-year period, or a 27 percent increase, and in the 100 percent, it went up by 4.26 percent, or a 42 percent increase over that timeframe, between 2012 and 2018.

And this seems like both, a large number, an increase of 200,000 additional veterans being qualified as having a disability requiring compensation over that period of time, and then also a shift, as well, in those receiving higher levels of compensation.

So, do you have a reason or a cause to attribute this rise to?

Mr. LAWRENCE. I would be happy to talk to you in more detail about this. The numbers reflect what we are seeing as veterans apply for benefits broadly—and I know your analysis is not broad—broadly, as our population of veterans ages, and we understand more about the medicine and the problems that they are dealing with. They are applying for claims and we are adjudicating them. That is what you are seeing taking place in those numbers; they are accessing the benefits that they have earned.

Secretary WILKIE. I didn't finish answering your first question about 39,000, 40,000 veterans who have—Blue Water veterans who have at least one Agent Orange condition have been treated by VA for that condition. So, this is not a zero-sum game. We are actually in the process of—

Ms. LURIA. But when you refer to that approximately 39 or 40,000 people, because this ruling is recent, they would already be treated for other reasons that qualify them for a disability; is that correct?

Secretary WILKIE. For Agent Orange, right. For Agent Orange conditions; the conditions that are listed as conditions that we have to treat as a result of the Agent Orange Act.

It is not as if under Blue Water, we are going to be starting afresh. We have thousands of veterans who are being treated who fall into that category.

Ms. LURIA. They fall into that category because they served in that time and place, but they are currently being treated and they are rated for a disability because of other causes, because this was not previously recognized as a standalone cause; is that correct?

Mr. LAWRENCE. So, again, let me take you into the weeds. If you were on a ship in the Blue Water and you came onto the land, you then now had access to the presumptive, because you are on land, and that is where the presumptive covers you. Some of what the secretary is referring to is that sort of taking place.

Ms. LURIA. Thank you.

Dr. STONE. Congresswoman, I think you are substantially correct in your assumption that part of that tens of thousands that we are currently treated are not related to their Blue Water service; it has to do with other forms of disability.

Ms. LURIA. Thank you.

The CHAIRMAN. I now recognize Ms. Underwood for 5 minutes.

Ms. UNDERWOOD. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for appearing before the panel today.

Based on the most recent data available, the suicide rate was one and a half times greater for veterans than non- veteran adults and based on that same data, the suicide rate for women veterans was 1.8 times higher than the suicide rate for non-veteran women. While the population of women veterans continues to grow, the actual number of female veterans makes research into the population difficult and more expensive.

And so, Secretary Wilkie, how is the VA incentivizing research into risk factors for suicides specific to women veterans, and does your suicide-prevention requests or research requests include funds for this more expensive, yet important research?

Secretary WILKIE. Well, our budget for suicide prevention is about $222 million.

Ms. UNDERWOOD. Uh-huh.

Secretary WILKIE. That is about $16 million over last year.

Ms. UNDERWOOD. Uh-huh.

Secretary WILKIE. What has changed is that I am now in charge of a national suicide-prevention effort and as a result of the President's executive order, on the task force. The goal of this task force is to treat suicide prevention in a way that we have not, and that is a whole-health, Whole-of- Government Approach.

My view is that we bring together NIH, HHS, DoD, and we strike at the heart of those causes of suicide with our veterans, but more importantly—and this applies to both men and women—14 out of the 20 veterans who take their lives every day are not in the VA system.

Ms. UNDERWOOD. Right.

Secretary WILKIE. My goal is to open the aperture of funding to the states and localities to allow them outreach into the community to help us find them. I will give you an example. I was in Alaska in October. Half of the veterans in Alaska are outside of VA and I asked the Alaska Federation of Natives to double the number of veterans' tribal representatives that they have in order to reach those veterans.

That is absolutely essential. Not only in rural—

Ms. UNDERWOOD. Sir, I am going to ask you to focus on the research part.

Secretary WILKIE [contined].—but also in the urban areas.

You want to hit research?

Ms. UNDERWOOD. Please.

Dr. STONE. I think there is a number of very troubling things about the population of female veterans. High rates of pain, as much as 70 percent complaining of chronic pain—

Ms. UNDERWOOD. Sure.

Dr. STONE [continued].—high rates of military sexual trauma; as mentioned previously by one of your colleagues, 30 percent—29.1 percent with history of military sexual trauma; about 40 percent with mental health-related issues. But that is in the 25 percent of women veterans that we have attracted to the system. For the other 70—

Ms. UNDERWOOD. Sir, I would like to ask you to specifically focus your comments on the research dollars and any incentives to study the female veteran.

Dr. STONE. Yeah. So, my specific answer to that is, what we have to do is find the reasons that the other 75 percent of American women veterans are not choosing us.

Ms. UNDERWOOD. I understand the research question. I am talking about the funding.

Secretary WILKIE. I will answer that. That is the reason for the Suicide Task Force.

Ms. UNDERWOOD. I understand—

Secretary WILKIE. That is to go outside of VA to pull in the research capabilities of NIH, DoD, and HHS—

Ms. UNDERWOOD. Okay.

Secretary WILKIE [continued].—because they have more expansive research capabilities than we have. In my discussions with the White House about that, that is what I insisted upon.

Ms. UNDERWOOD. So, are you saying that there is no incentive in your current structure or in this current budget request for the VA suicide-prevention research funding to focus on women veterans who have a higher risk of suicide: yes or no?

Dr. STONE. I think there is incentive.

Ms. UNDERWOOD. What is that incentive?

Dr. STONE. I think that incentive is the programs that we have set up specifically for women veterans and to attract, train, and retain those medical specialists that will support the reduction in harm to women.

Secretary WILKIE. It is to take care of all veterans who are on this terrible spectrum. And I would go beyond your question, because the research that we actually have that started before the President announced his task force includes what your colleague just said, homelessness and opioid abuse, which is on that spectrum that creates many of these problems.

So, a one-off VA program, in my opinion, was not sufficient to tackle the problems that you have addressed. That is why the President has created the national task force that will bring together all of the things that you just said you wanted, to focus on this one terrible issue.

Ms. UNDERWOOD. Okay. Well, any veteran suicide is tragedy and it is our goal with the dollars that the Federal Government, that the Congress appropriates for the Federal Government to spend in this area to be properly used. We know that there is a problem specifically of the subset of female veterans and we need to make sure that as we do the research in the Whole-of-Government Approach, that there is a specific targeting of this female veteran's population, okay.

And so, I think that we do need to outline some kinds of incentives to get there and we are happy, as a Committee, to help work with you to do that.

Mr. Chairman, thank you.

The CHAIRMAN. I now recognize Mr. Mast for 5 minutes.

Mr. MAST. Thank you, Mr. Secretary for waiving me onto the Committee or thank you, Mr. Chairman, for waiving me onto the Committee.

Thank you, Mr. Secretary, for being here.

Secretary WILKIE. Thank you, sir.

Mr. MAST. I was glad to see you take this post. We have known each other for a number of years. I need to ask you about some things going on back in my own—

Secretary WILKIE. Yes.

Mr. MAST. Are you aware of what happened at the West Palm Beach VA on March 14th, 2019?

Secretary WILKIE. I am aware of several instances of tragedy that happened at West Palm Beach—suicide, an attempt at police-induced suicide, at West Palm Beach, yes.

Mr. MAST. Yes. March 11th, Bruce Dash came in under a Baker Act for suicidal thoughts. March 14th, he was found at 6:00 p.m. dead on the mental health ward, unfortunately tragic, as you said.

February 27, Larry Bond, admitted, again, under a Baker Act, drew a gun from his motorized scooter and shot Dr. Bruce Goldfeder, another bystander; again, very, very tragic.

Not that you would be expected to know this, but going back to January 10th of 2018, I visited the Department of Veterans Affairs, here in Washington, specifically to discuss Veterans Affairs security issues nationwide, but very specifically, back home.

May 30th of 2018, my legislative director met with the administration at our local VA hospital, came down and met with the administration there about security issues local to the hospital.

On June 29th, 2018, I met with the West Palm Beach VA director about security concerns that we had in the facility. Weekly, my staff and I, we hold office hours at the West Palm Beach VA, where we have spoken to the security personnel about the issues and concerns that we have here.

I would like to know, Mr. Secretary, have you or Dr. Stone before to the West Palm Beach VA since the recent suicide and recent shooting?

Dr. STONE. I have not. My director of mental health services will be down there later this week.

Mr. MAST. Mr. Secretary, have you been?

Secretary WILKIE. No, I have not; although, as you know, that was the very first place that I visited when I became the secretary. We are, as a result of what happened at Palm Beach, we have a new security protocol in place that will apply to the entire country.

But you have hit on an issue that is wider than your district. Last year, I believe 19 veterans across the country took their lives in various VA facilities and as a result of that, we have undergone a complete review of our security protocols. We found that on the medical front that these are not connected; that there is not one pattern.

But what happened at Palm Beach with the wounding of the 3 medical professionals, has led us to revamp the entire way we do security. Because I will tell you that the method that was used there was entirely unexpected.

Mr. MAST. I am glad to hear that. I believe that these tragic events, they warrant your direct attention, as well as you, Dr. Stone. So, I am asking for the most valuable thing that you both have to offer; that is your time.

Will you give us your time in West Palm Beach, come down, let us show you our concerns in the facility. Meet behind closed doors with our veterans that would love to have the chance to speak to you both about what they are experiencing, what they are seeing, what they are concerned about. Will you give us your time, come down to the West Palm Beach VA? I am asking this to both of you.

Secretary WILKIE. Well, I am in Florida quite a bit, and, of course, I will come.

But let me refer back to an answer that I gave earlier.

Mr. MAST. So, I have your commitment?

Secretary WILKIE. I will be happy to come with you.

Mr. MAST. Will you meet—

Secretary WILKIE. I will meet with everybody. I would meet with everybody; in fact, in the first 3 months that I was secretary before this current condition got me and I couldn't travel, I was in almost 20 states—I think 20 states.

Mr. MAST. Before my time runs out, can you give me a timeframe when yourself, when Dr. Stone will find time to meet, most importantly, with my local veterans. I know that we have access to one another—

Secretary WILKIE. I will say as soon as possible, but let me also finish by saying—

Mr. MAST. I was a bomb technician. We used to always use vague terms like that so people would never know exactly when we would get on the ground. I would like a more specific answer.

Secretary WILKIE. Well, the problem is that as a secretary, I don't control my own time, so I have to respond to the entire country. And that is what I was going to answer in this sense of what I just said about suicide. Palm Beach had tragedies. The thrust that we have undertaken—and Palm Beach, if you go back and listen to my remarks in the Roosevelt Room in the White House, I said that Palm Beach was the final impetus that got us across the finish line in creating a national suicide task force. It was Palm Beach that allowed the President to put his signature on the Suicide Task Force. I said that at the signing ceremony.

Because Palm Beach is indicative of what we are seeing across the country, and my thrust is national. Obviously, I will go as many places as I can, but as the leader of this institution, I am taking, as a result of what happened in your district, a national approach that is now buttressed by the President of the United States and his emphasis on suicide.

Mr. MAST. Thank you, Mr. Secretary. I will look forward to seeing you back home.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, I thank you for your testimony, and the first panel, you are now excused.

Mr. ROE. Let me ask him one question, and not to get answered on the way out the door, but give me an answer to this.

The CHAIRMAN. Mr. Roe?

Mr. ROE. Yeah, just a very simple thing for you all. I saw your opioid initiative and I just wonder how many inpatient treatment facilities that the VA has for opioid addiction across the country. And you can answer—the secretary—the Chairman has been very kind to let me ask the question.

Secretary WILKIE. Can I take that one for the record, Doctor?

Mr. ROE. Yes.

Secretary WILKIE. I don't know off the top of my head.

Mr. ROE. I think I would like to know that because I think it would probably be inadequate.

The CHAIRMAN. All right. The panel is excused.

Thank you, Mr. Secretary, again, for your testimony.

I am going to, out of mercy for, I would presume myself, but also maybe Dr. Roe, a 5-minute recess before we call the next panel.

[Recess.]

The CHAIRMAN. I now invite our second panel to the witness table: Ms. Joy Ilem, the National Legislative Director for Disabled

American Veterans; Mr. Patrick Murray, representing the Veterans of Foreign Wars; Ms. Heather Ansley, representing Paralyzed Veterans of America; and Mr. Larry Lohmann, Senior Legislative Associate of the Legislative Division from The American Legion.

Ms. Ilem, I now recognize you for 5 minutes.

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Chairman Takano, Ranking Member Roe, and Members of the Committee.

On behalf of the co-authors of the Independent Budget, DAV, PVA, and VFW, representing our more than 2 million members, I am pleased to present our views regarding the President's funding request for the Department of Veterans Affairs for fiscal year 2020.

For more than 30 years, our organizations have worked together to develop Independent Budget and policy recommendations that reflect the true needs of America's veterans. We believe the implementation of the VA MISSION Act reforms, along with the projected increased demand for veterans of benefits and medical care both, inside VA and in the community, validates our funding increases we are recommending for 2020.

The IB recommends total discretionary funding of $103 billion to ensure the VA is able to fully and faithfully implement the MISSION Act and deliver timely benefits to veterans, their families, and survivors, and provide medical care service to all enrolled veterans using VA care.

We appreciate that Congress remains committed to improving services for our Nation's veterans; however, the serious access problems in the health care system identified in 2014 and the ultimate passage of the MISSION Act have created high expectations which, absent sufficient resources to fully enact the law, could erode promised reforms and modernization.

To ensure these promises are kept, the IB recommends approximately $88 billion in total medical care funding for fiscal year 2020; $4 billion more than the Administration's request. Of the $88 billion, we recommend $70 billion to fund VA-provided medical care and the remaining $18 billion for Community Care funding; nearly double current funding levels.

The amount includes $8.5 billion to meet all related VA MISSION Act requirements, including replacing the Veterans Choice Program and the new Veterans Community Care Program by the start of fiscal year 2020, and expanding transplant-care services and implementing the new urgent care benefit.

The Administration's request for VA medical services is approximately $4.7 billion below the IB recommendation of $56 billion. Although the Administration's request reflects an apparent increase of 3 percent, the IB believes that when taken into account the increased costs to maintain current services, anticipated increases in workload, as well as increased costs for projects inside VA mandated by the MISSION Act, that the apparent increase falls short of what may be needed.

The $56 billion includes an additional $1.2 billion for several other important health care programs to include increased funding for VA's long-term care services, its comprehensive caregiver program, the women veteran's health program, reproductive services,

and prosthetics and sensory aids program. The IB recommends $6.1 billion for information technology to sustain VA's electronic health record modernization efforts and to reverse the trend of underfunding development and innovation of IT. We strongly believe IT improvements are critical to the overall success of reform efforts underway. The IB recommends $840 million for medical and prosthetic research. VA's research program ensures ill and injured veterans have access to the most advanced evidence-based and cost-effective treatments available; one of VA's core missions.

The Administration's request of $762 million for this critical program represents a 2 percent cut below current funding, compounded by medical research inflation estimated to be 2.8 percent.

The IB recommends $3.5 billion for VA's major- and minor-construction programs to repair, renovate, expand, and replace VA's aging infrastructure. The Administration's request of $1.8 billion represents a 44 percent reduction from VA 2019 levels and a significant retreat in funding when VA estimates at least $60 billion necessary over the next 10 years to address VA's infrastructure issues.

Finally, while the Administration's recommended funding level of $3 billion for the Veterans Benefit Administration is sufficient, we oppose several proposals that would negatively impact veterans; specifically, we oppose the rounding down of cost-of-living adjustments and making it harder for veterans to receive examinations necessary to establish their disability claims.

In closing, we thank you for the opportunity to testify today and present our budget views and recommendations for fiscal year 2020 and we would be happy to answer and respond to any questions that you or Members of the Committee may have. Thank you.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

The CHAIRMAN. Mr. Lohmann, you are recognized for 5 minutes.

STATEMENT OF LARRY LOHMANN

Mr. LOHMANN. Chairman Takano, Ranking Member Roe, distinguished Members of the Committee, on behalf of Brett P. Reistad, national commander of The American Legion, and our nearly 2 million members, we thank you for the opportunity to present our position on President Trump's proposed fiscal year 2020 budget for the Department of Veterans Affairs.

Last month, The American Legion celebrated our 100th anniversary. When National Commander Reistad testified earlier this year before a Joint Committee on Veterans Affairs, he spoke about The American Legion's mission: a mission to care for veterans, a mission to provide patriotic youth programs, a mission to advocate for strong national defense, and a mission to instill pride about what it means to be American. As he said, our mission continues.

Inherently, an adequately funded VA budget provides care to veterans and that makes it a paramount objective in the The American Legion's mission. The American Legion generally supports the President's proposed budget for fiscal year 2020 as it applies to VA programs, though we believe additional funding is needed in several areas.

We appreciate the continued commitment of the President, Congress, and the Committee following through with promises made to care for those who have served our great country in uniform. The fact that the Department of Veterans Affairs is only one of two civilian agencies that will experience an increase in funding in 2020 is not lost on The American Legion. At a time when most federal agencies are experiencing a decrease in their respective budgets, the VA, will hopefully, with assistance from this critical committee, receive a much-needed increase in line with, or greater than the President's proposal.

As VA continues to serve the veterans of this Nation, it is vital the secretary has the necessary tools and resources to ensure that those who have served receive timely, professional, and courteous service. They have earned it.

Today, I will focus on a few key issues highlighted in the budget: implementation of the VA MISSION Act, appeals modernization, and COLA round downs. The 115th Congress was very productive in enacting veteran legislation.

One critical piece of legislation championed by The American Legion was the VA MISSION Act. If faithfully implemented, the VA MISSION Act will expand the availability of high-quality medical care to veterans in a timely manner. Two of the most notable functions of the VA MISSION Act include reforms for the Department of Veterans Affairs health care system and expanding the VA's caregiver service support program.

MISSION consolidated 7 existing Community Care programs, including the Veterans Choice Program, and further expanded VA Caregiver Support Program to eligible veterans severely injured prior to September 11th, 2001. The underlying principles behind the creation of these programs is fundamentally sound; however, success of these programs depend upon the existence of sufficient resources.

Under the President's proposed budget, we are concerned with the ability of VA to expand its comprehensive Caregiver Support Program to severely injured World War II, Korean, and Vietnam War veterans and their family caregivers under the statutorily mandated timetable.

VA MISSION Act will require more resources that have been provided through regular appropriations in fiscal year 2019 and will cause care-appropriation needs for the VA for future fiscal years. These appropriation needs must be addressed by Congress.

Also passed by the 115th Congress, the Appeals Modernization Act. The Appeals Modernization Act, or MA, became fully effective earlier this year. The MA sets forth specific elements that VA must address in its implementation.

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. As such, we feel we have a vested interest in the success of this new system.

The American Legion believes working together with VA and Congress is vital to ensuring the success of the new appeals system. The American Legion supports the funding of the President's budget as it applies to VA programs and urges Congress to appro-

priate this money as it uses its oversight authority to make sure stakeholder voices continue to be heard.

In addition to funding newly implemented laws, care for veterans means making sure long-existing programs continue to operate as they were intended to. The President's proposed budget seeks multiple cost-of-living adjustment round downs. These round downs would impact both, dependency indemnity compensation, as well as education programs.

The American Legion, through resolution, opposes these round downs. The effect of these proposed round downs would serve as a tax on disabled veterans and their survivors, decreasing the amount of money they receive each year. Veterans and their survivors rely on their compensation for cost-of-living to make sure essential purchases, such as transportation, rent, utilities, and food.

The American Legion is opposed to any COLA round down. The Administration and Congress should not seek to balance the budget on the backs of veterans who have served their country.

In closing, Chairman Takano, Ranking Member Roe, and distinguished Members of this Committee, The American Legion stands ready to work with Congress and the VA. We understand with creative solutions that have been made possible with innovative legislation enacted by the last Congress, come new questions to be answered. Together with cooperation and by remaining flexible, we will make these programs work and answer those questions for America's veterans.

The American Legion thanks you for the opportunity to share with you this afternoon, and I am happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF LARRY LOHMANN APPEARS IN THE APPENDIX]

The CHAIRMAN. Ms. Ilem and Mr. Lohmann's full written testimony will be included in the hearing record.

I now recognize myself for 5 minutes, and I want to begin by asking our VSO representatives this question. The Administration has stated this budget proposal would provide the highest funding levels in the Department's history. In many of your testimonies, you expressed concern that the Administration's request was not wholly sufficient to provide for both, VA's internal capacity and the full and faithful implementation of the MISSION Act.

What do you believe will be the consequences for veterans if this budget is adopted as is, beginning with Ms. Ilem?

Ms. ILEM. If it was adopted, as is, without the additional funding, we believe, you know, there could be severe consequences, again, for veterans. We might be back in the same situation with access issues that occurred.

With this big—with the implementation of the MISSION Act, it is such a critical period right now, we are not sure how the access standards are going to work, how this is all going to roll out, obviously; there are a lot of unknowns. So, we want to make sure that veterans—this, you know, goes as seamless as possible for them.

And we want to make sure that a sufficient budget is there to support VA. So, whether they need to continue to make the reforms inside that they have promised, in terms of the IT reforms and all

the other hiring of clinical staff and the other necessary improvements in VA, as well as be able to build their network and be able to make sure that veterans have access to that Community Care if VA is not able to provide it.

The CHAIRMAN. Mr. Lohmann?

Mr. LOHMANN. Thank you, Mr. Chairman, for the question. We share your concerns with the funding of the VA. We have a system we are saving that goes out and visits VAs through the year and we have 2 million members that are regularly participating in the VA system.

We believe that once those problems become recognizable, we would be able to react to it. And I think that it is something that we will keep monitoring and we want to address proactively, but we want to see how the funding is currently working that has been appropriated.

The CHAIRMAN. Mr. Murray?

Mr. MURRAY. Sir, I believe that it is—I agree with our partners in the IB. It is absolutely critical that this funding is done properly and make sure that the attention for the right programs is being put on different parts within the budget appropriately. I think that just saying that it is a higher dollar amount isn't enough if the right attention isn't being given to the right areas.

The CHAIRMAN. Ms. Ansley.

Ms. ANSLEY. Thank you, Chairman, for the question. PVA, as part of the Independent Budget, believes that if the budget were implemented as requested, that it would leave shortfalls in key areas, including the implementation of the VA MISSION Act to Community Care, medical research, and through VA's provision of care through its direct-care system. And we believe, ultimately, as was stated by our partners, it would lead to problems that we have seen in the past and also to veterans not receiving the care that they have deserved and earned.

The CHAIRMAN. Thank you. The VA's shift toward a public health approach to suicide prevention has led the agency to begin developing veteran-focused community-based support systems. Do any of you believe that the VA does enough to prepare a veteran's personal support system, his or her family or friends, to understand and respond to the red flags that often indicate suicidality? Anyone who would care to start—Ms. Ilem, go ahead.

Ms. ILEM. Certainly VA's public health approach is a big challenge for them. I mean, they are reaching way beyond their capacity internally and trying to reach those veterans who haven't engaged with VA.

VA has tried to provide a number of—they have a number of programs on suicide prevention and that are on their website available—the Be There campaign—and a number of ones that are specifically about outreaching to family members, looking at red flags, trying to coach veterans into care that—are a family member might be reaching out to the VA saying, I think my loved one, my veteran needs help, but they are very resistant in doing it, what can I do?

So, I know that they are trying, but it is very insular within VA. So, hopefully, this program, the public approach, they will share some of that information wider, to this wider network in the community, because I think they do have some excellent programs that

they have tried to set up to make that information available to family members about the red flags. And they are also doing a lot of outreach to veteran service organizations on their suicide hotline, you know, the crisis line, and how to spot when people are in trouble, and especially when they call in and you just might be talking to a veteran on the phone, how to pick up on signals that there might be something serious and that how you can help get that veteran the help that they need.

The CHAIRMAN. Thank you. My time is expired.

I now recognize Dr. Roe for 5 minutes.

Mr. ROE. Thank you, Chairman.

And thank you all for being here, and thank you for your partnership over the last several Congresses in trying to advance the status of our veteran population in the country.

One of the things that I was asking Jon here during the first panel was, how much money does the VA carryover? How much money that they had, that they did from fiscal year 2014, 2015, 2016, whatever, how much they have carried over, and it is my understanding—and we sort of looked it up. It is about $3 billion in health care.

Does that give you all some peace of mind to know that there will be plenty of enough resources to take care of the needs that you just discussed? And anyone can take that.

Mr. MURRAY. Sir, yes. We have found that same number, but one of the questions we actually have for VA is: What is that money targeted for? If they are just simply putting it in, you know, a general fund is one thing, but making sure that it is—in the past, those monies have gone to Community Care to fund extension for that. There have been some excess monies that have gone to the Filipino Veterans Fund that they have had extra, almost slush money to put there.

What we would like to see is that this money is being kind of allocated for specific programs, and then we would like to be a little bit more reassured about where that is going, sir.

Mr. ROE. Yeah, we can help. Believe me, they will have to answer to this Committee, so I think we have a lot of leverage there on that issue.

We were talking a lot about—and the Chairman and I have agreed that one of our focuses will be on suicide prevention—and we spend a tremendous amount of money on suicide prevention, to the tune of billions of dollars and we haven't moved the needle at all. So, we are looking at alternative ways or whatever, and if you all would assist us in that, if you find out there when you are traveling, you are all out there in the country and your members are, NGOs or others that are doing this that are having some success, please share those with us, because we would like to see if those are scalable.

And we are looking at things that are, already, and changing some of the things that we are currently doing. I know that the effort is there. I know the will of the Congress and the President; the Administration is there. We just have not seen the results and I am not sure why. I wish I had the answer to it.

One little something we looked up, which is really astonishing to me, in fiscal year 2020, the budget request for homeless veterans,

as treatment costs and initiative spending, is $9.3 billion, and the fiscal year 2020 budget request for Post-9/11 veteran medical needs are 8.3. We are actually spending more money on medical needs and initiatives and homeless veterans than we are our Post-9/11-injured veterans. I found that an amazing number.

And with today's economy being what it is, as good as it is, I think we also need to do—and the Chairman and I have also talked about this—to do a deep dive on homeless veterans and find out—and I think it was mentioned by one of our colleagues here—in California, a huge number of homeless veterans are in Southern California, mainly.

So, if you could help us with that, we would be—I would much appreciate that. And any of you can make a comment if you would like.

Ms. ANSLEY. Thank you, Ranking Member Roe.

Certainly, the Independent Budget spoke to the needs of homeless veterans, as it has. We continue to work together to ensure that every veteran is able to be housed and receive the care and services they need to be able to live full lives.

And we commit to working with you and the Committee, continuing on that issue. We know it has been an initiative for a number of years and Congresses, but as you said, there is still more to be done and we want to make sure that we are a part of that solution.

Mr. ROE. And it is one of the VA's successes. I mean, I have met veterans out there who have been homeless. I met one in Nashville not long ago that was out of the street and had a HUD voucher, had a job, and is doing great. And I have run across that many, many times. So, I don't think that we hear those stories enough.

We talk about the things that's not happening, but we should talk about the things that have happened, positively, and that is one of the things.

And very quickly, because my time is about gone, please elaborate on the Independent Budget's contention that the current budget request will not allow VA to fully and faithfully implement the MISSION Act.

Ms. ANSLEY. Thank you, Ranking Member.

The Independent Budget's recommendation for the Community Care effort was $18.1 billion versus the Administration's request of $15.3 billion. We have concerns that that funding is not going to be sufficient to meet the requirements. Also, our estimates did not include the access standards as it relates to the drive time and wait lists that recently came out from the Administration in looking at access standards.

So, we have concerns moving forward that will be sufficient funding to address all of those needs. There is a lot of unknowns still. Even, you know, 60 days out or so as the program is beginning into effect is how many veterans are going to be using that. The marketing assessments are not complete to know what resources are available in the community. And all of those come together to just give us pause that there may not be sufficient funding available.

Mr. ROE. Thank you. I yield back.

The CHAIRMAN. I now recognize General Bergman for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

I guess the only thing between us ending is me; is that right? Okay. Well, then, let's get right to the meat of the point, and this is your chance.

What is the one heartburn that each of you have with the budget?

Mr. LOHMANN. I think, principally, the one thing that really hits—resolutions is the COLA round downs. I think every time that these come up, every single budget is something that we continually have to keep sticking to is that these round downs affect veterans and it turns into a tax every single time to nickel-and-dime our veterans that have served and continue to rely on this money for rent and tight budgets, and to incrementally chip away at it.

Mr. BERGMAN. So, round downs, okay.

This is like one of these one-minute speed rounds.

Mr. MURRAY. So, sir, for my portion, I would say aging infrastructure. The VA is not properly funding its capital infrastructure program. There are billions of dollars of seismic correction that need to be done that are not being funded at anywhere an appropriate rate to get rid of those.

Mr. BERGMAN. Okay. So, infrastructure?

Mr. MURRAY. Infrastructure.

Ms. ILEM. I would say women veterans. As part of the Independent Budget, we requested an additional $76 million. VA has made a lot of progress, but we really want to see more being done. A number of the members today talked about there was concern over women veterans' issues within VA and how they are going to resolve them.

Mr. BERGMAN. Okay. So, process? Bureaucratic? I am trying to get a word down—get it down to a word.

Ms. ILEM. Culture issues, and just having enough focus on making sure that VA has the providers it needs that have expertise in women's health to serve the small—it is a small population: 500,000—but it is growing. It grew 175 percent over a short period. So, VA has been playing catchup.

Mr. BERGMAN. Okay.

Ms. ILEM. So, between just making sure culture, that all women veterans feel welcome, and feel that they are being, you know, treated with dignity and respect, just like any veteran—

Mr. BERGMAN. Okay.

Ms. ILEM [continued].—and we want to make sure that all veterans can go to VA and take advantage of their great services.

Mr. BERGMAN. Culture?

Ms. ILEM. Yes.

Mr. BERGMAN. Okay.

Ms. ANSLEY. I would say the decrease that we have seen in medical research. IB recommended $840 million. The Administration came in at $762 million. This will not even keep up with the rate of medical inflation that occurs.

And, certainly, research is important to all types of issues, and, particularly, to PVA members.

Mr. BERGMAN. Okay. I appreciate your candor and I appreciate your directness. One of the challenges that we have as a Committee, whether it be round downs, infrastructure, culture, medical research, is that how do we get the most bang for our buck? And

what we count on for everybody, whether it is the VA or the VSOs, is that we look, honestly, at how much value we are getting for our dollar and being able to say—I am just going to pick on infrastructure for a second here, because it is—we don't need more buildings, necessarily, but we need places for veterans to get health care.

So, anyway, my point is we got that review. I am not asking for a response, okay, but the idea is how do we get our veterans the health care in a timely manner? And it is quality health care, whether it is through telehealth, whether it is through CBOCs, whether it is through the VA hospital, whether it is through whatever it happens to be. So, the goal is the same. The question is: How do we get there?

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. I have a few words that I would like to say before I close the hearing.

While I appreciated the secretary and the members of the senior staff of the VA appearing before us today, I had hoped that they would remain to hear the concerns of our VSOs and I am disappointed that they did not do so.

But I want you to know that we have heard your concerns. I have heard your concerns, and we will be working closely with all of you.

I did want the VA to hear—and this will go into the record—that when this Committee invites a VA witness to participate in the hearing, the VA is required to make that witness available to provide testimony until that witness has been excused, and I am willing to work with the Department if it believes another witness would be more appropriate, and work to schedule hearings when the witnesses are available.

The VA's refusal to provide a witness at the Technology Modernization Subcommittee hearing yesterday was unacceptable. If the VA refuses to make witnesses available, I will take steps to compel the appearance of witnesses, if necessary.

With that, I will say that all Members will have 5 legislative days to revise and extend their remarks and include extraneous material.

Again, thank you for appearing before us today, and this hearing is now adjourned.

[Whereupon, at 4:59 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of David P. Roe, Ranking Member

When I came to Congress in 2009, the Department of Veterans Affairs' (VA's) budget totaled $97.7 billion.

Today - a decade later, despite years of fiscal austerity that has impacted virtually every other Federal agency - that budget has more than doubled.

Coming in at just over $220 billion - an increase of 9.6 percent above 2019 - the Trump Administration's fiscal year (FY) 2020 budget submission once again requests a record amount of funding for VA.

I commend the President for his unflagging commitment to investing in our Nation's veterans and ensuring that they receive the support they need from the government they fought for.

This budget reflects our mutual goal of strengthening VA by increasing easy access and timely receipt of care, benefits, and services to veterans across the country.

It continues to advance the important modernization efforts that this Committee has prioritized and Secretary Wilkie has since championed, including electronic health record modernization.

It also funds the implementation of the MISSION Act, which will transform the VA health care system and benefit veteran patients for years to come.

I am grateful to Secretary Wilkie and his team as well as to the representatives from the veteran service organizations for being here this afternoon and I look forward to hearing from them shortly.

But - before I yield, Mr. Chairman - I want to address Secretary Wilkie's comments before the Senate Veterans' Affairs Committee last week regarding VA's physical infrastructure requirements.

Mr. Secretary, you testified that the Department has a $60 billion capital investment need over the next decade.

You and I both know that that need is far from new and that it exists in large part because of how costly and complicated it is to operate a health care system whose medical facilities are five times older than they are in the private sector.

I wholeheartedly agree with you that the Asset and Infrastructure Review (AIR) Commission that was included in the MISSION Act is key to addressing that need and should be ready to go as soon as the Department has completed the market assessment process that will inform the Commission's work.

I understand that the market assessments are on track to be complete by next summer and I want to work hand-in-hand with VA to remove any barrier that stands in the way to getting the Commission underway not long after that.

I thank all of our witnesses once again for being here.

Prepared Statement of Robert L. Wilkie

Good afternoon, Mr. Chairman, 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) 2020 Budget for the Department of Veterans Affairs (VA), including the FY 2021 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, and Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer.

I begin by thanking Congress and this Committee for your continued strong support and shared commitment to our Nation's Veterans VA. In my estimation, two Federal Government departments must rise above partisan politics-the Department of Defense (DoD) and VA. The bipartisan support this Committee provides sustains that proposition. To continue VA's momentum, the FY 2020 budget request fulfills the President's strong commitment to Veterans by providing the resources necessary

to improve the care and support our Veterans have earned through sacrifice and service to our country.

Fiscal Year (FY) 2020 Budget Request

The President's FY 2020 Budget requests $220.2 billion for VA - $97.0 billion in discretionary funding (including medical care collections). The discretionary request is an increase of $6.8 billion, or 7.5 percent, over the enacted FY 2019 budget. It will sustain the progress we have made and provide additional resources to improve patient access and timeliness of medical care services for the approximately 9 million enrolled Veterans eligible for VA health care, while improving benefits delivery for our Veterans and their beneficiaries. The President's FY 2020 budget also requests $123.2 billion in mandatory funding, $12.3 billion or 11.1 percent above 2019.

For the FY 2021 AA, the budget requests $91.8 billion in discretionary funding including medical care collections for Medical Care and $129.5 billion in mandatory advance appropriations for Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities benefits programs in the Veterans Benefits Administration (VBA).

For VA Medical Care, VA is requesting $84.1 billion (including collections) in FY 2020, a 9.6 percent increase over the 2019 level, and a $4.6 billion increase over the 2020 AA, primarily for community care and to transition the Choice Program workload to VA's discretionary Medical Community Care account. This Budget will provide funding for treating 7.1 million patients in 2020.

This is a strong budget request that fulfills the President's commitment to Veterans by ensuring that they receive high-quality health care and timely access to benefits and services while concurrently improving productivity and fiscal responsibility. I urge Congress to support and fully fund our FY 2020 and FY 2021 AA budget requests - these resources are critical to enabling the Department to meet the evolving needs of our Veterans and successfully execute my top priorities.

Customer Service

It is the responsibility of all VA employees to provide an excellent customer service experience (CX) to Veterans, Servicemembers, their families, caregivers, and survivors when we deliver care, benefits, and memorial services. I am privileged to champion this effort.

Our National Cemetery Administration has long been recognized as the organization with the highest customer satisfaction score in the Nation. That's according to the American Customer Satisfaction Index ACSI). And that's across all sectors of industry and government. We need to work to scope that kind of success across all benefits and services.

That's why I incorporated CX into the FY 2018–2024 VA Strategic Plan. Last year, I issued VA's first customer service policy. That policy outlines how VA will achieve excellent customer service along three key pillars: CX Capabilities, CX Governance, and CX Accountability. I am holding all VA executives, managers, supervisors, and employees accountable to foster a climate of customer service excellence. We will be guided by our core VA Values of Integrity, Commitment, Advocacy, Respect, and Excellence (I–CARE). These values define our culture of customer service and help shape our standards of behavior.

Because of VA's leadership in customer experience, our Veterans Experience Office has been designated Lead Agency Partner for the President's Management Agenda (PMA) Cross-Agency Priority (CAP) Goal on Improving Customer Experience across government.

Our goal is to lead the President's work of improving customer experience across Federal agencies and deliver customer service to Veterans we serve that is on par with top private sector companies.

This is not business as usual at VA. We are changing our culture and putting our Veteran customers at the center of our process. To accomplish this goal, we are making investments in Customer Service, and we are making bold moves in training and implementing customer experience best practices.

Veterans Experience Office. The Veterans Experience Office (VEO) is my lead organization for achieving our customer service priority and providing the Department a core customer experience capability. VEO offers four core customer experience capabilities, including real-time customer experience data, tangible customer experience tools, modern technology, and targeted engagement. For FY 2020, VEO is shifting from a full reimbursable authority (RA) funding model to a hybrid of a RA and budget authority (BA) model. The FY 2020 request of $69.4 million for the VEO ($8.6 million in BA and $60.6 million in RA) is $8.1 million above the FY 2019 enacted budget. The budget increase and the transition to a BA highlights VA's

commitment to customer service and the institutionalization of CX capabilities within the Department to improve care, benefits and service to Veterans, their families, caregivers and survivors.

MISSION Act Implementation

The VA MISSION Act of 2018 (the MISSION Act) will fundamentally transform elements of VA's health care system, fulfilling the President's commitment to help Veterans live a healthy and fulfilling life. It is critical that we deliver a transformed 21st century VA health care system that puts Veterans at the center of everything we do. The FY 2020 budget requests $8.9 billion in the VA Medical Care program for implementation of key provisions of the MISSION Act: $5.5 billion for continued care of the Choice Program population; $2.9 billion for expanded access for care based on average drive time and wait time standards and expanded transplant care; $272 million for the Urgent Care benefit, and $150 million to expand the Program of Comprehensive Assistance for Family Caregivers.

Access to Care. Over the past few years, VA has invested heavily in our direct delivery system, leading to reduced wait times for care in VA facilities that currently meet or exceed the quality and timeliness of care provided by the private sector. And VA is improving access across its more than 1,200 facilities even as Veteran participation in VA health care continues to increase.

From FY 2014 through FY 2018, VA saw an increase of 226,000 unique patients for outpatient appointments (a four percent increase). Since FY 2014, the number of annual appointments for VA care is up by 3.4 million. There were over 58 million appointments in VA facilities in FY 2018–620,000 more than the prior fiscal year. We have significantly reduced the time to complete an urgent referral to a specialist. In FY 2014, it took an average of 19.3 days to complete an urgent referral and in FY 2018 it took 2.1 days, an 89 percent decrease. As of December 2018, that time was down to about 1.6 days.

Still, our patchwork of multiple separate community care programs is a bureaucratic maze that is difficult for Veterans, their families, and VA employees to navigate.

The MISSION Act empowers VA to deliver the quality care and timely service Veterans deserve so we will remain at the center of Veterans' care. Further, the MISSION Act strengthens VA's internal network and infrastructure so VA can provide Veterans more health care access more efficiently.

Transition to the New Community Care Program. We are building an integrated, holistic system of care that combines the best of VA, our Federal partners, academic affiliates, and the private sector.

The Veterans Community Care Program consolidates VA's separate community care programs and will put care in the hands of Veterans and get them the right care at the right time from the right provider. On January 30, 2019, we announced proposed access standards that would determine if Veterans are eligible for community care under the access standard eligibility criterion in the MISSION Act to supplement care they are provided in the VA health care system. The proposed regulation for the program (RIN 2900–AQ46) was published in the Federal Register on February 22, 2019, and was open for comments through March 25, 2019.

New Veterans Community Care Program Eligibility Criteria

1. VA does not offer the care or services the Veteran requires;
2. VA does not operate a full-service medical facility in the State in which the Veteran resides;
3. The Veteran was eligible to receive care under the Veterans Choice Program and is eligible to receive care under certain grandfathering provisions;
4. VA is not able to furnish care or services to a Veteran in a manner that complies with VA's designated access standards;
5. The Veteran and the Veteran's referring clinician determine it is in the best medical interest of the Veteran to receive care or services from an eligible entity or provider based on consideration of certain criteria that VA would establish; or
6. The Veteran is seeking care or services from a VA medical service line that VA has determined is not providing care that complies with VA's standards for quality.

Proposed Access Standards. VA's proposed access standards-proposed for implementation in June 2019-best meet the medical needs of Veterans and will complement existing VA facilities with community providers to give Veterans access to health care.

1. **For primary care**, mental health, and non-institutional extended care services VA is proposing a 30-minute average drive time from the Veteran's residence.

2. **For specialty care**, VA is proposing a 60-minute average drive time from the Veteran's residence.

3. VA is proposing **appointment wait-time standards** of 20 days for primary care, mental health care, and non-institutional extended care services and 28 days for specialty care from the date of request, unless a later date has been agreed to by the Veteran in consultation with the VA health care provider.

	Primary/Mental Health/Non-institutional Extended Care	Specialty Care
Appointment Wait Time	Within 20 Days	Within 28 Days
Average Drive Time	Within 30 Min	Within 60 Min

VA remains committed to providing care through VA facilities as the primary means for Veterans to receive health care, and it will remain the focus of VA's efforts. As a complement to VA's facilities eligible Veterans who cannot receive care within the requirements of these proposed access standards would be offered community care. When Veterans are eligible for community care, they may choose to receive care with an eligible community provider, or they may continue to choose to get the care at their VA medical facility.

The proposed access standards are based on analysis of practices and our consultations with Federal agencies-including the DoD, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services-private sector organizations, and other non-governmental commercial entities. Practices in both the private and public sector formulated our proposed access standards to include appointment wait-time standards and average drive time standards.

VA also published a Notice in the Federal Register seeking public comments, and in July 2018, VA held a public meeting to provide an additional opportunity for public comment.

With VA's proposed access standards, the future of VA's health care system will lie in the hands of Veterans-exactly where it should be.

Urgent Care. This budget will also invest $272 million in implementing the new urgent (walk-in care) benefit included in the VA MISSION Act. On January 31, 2019, VA published a proposed rule that would guide the provision of this benefit using the provider network available through national contracts. Under the new urgent care authority, we will be able to offer eligible Veterans convenient care for certain, limited, non-emergent health care needs.

Caregivers. The MISSION Act expands eligibility for VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) under the Caregiver Support Program, establishes new benefits for designated primary family caregivers of eligible Veterans, and makes other changes affecting program eligibility and VA's evaluation of PCAFC applications. Currently, the Program of Comprehensive Assistance for Family Caregivers is only available to eligible family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. Implementation of the MISSION Act will expand eligibility to eligible 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 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.

Over the course of the next year, VA will be establishing systems and regulations necessary to expand this program. Caregivers and Veterans can learn about the full range of available support and programs through the Caregivers website, www.caregiver.va.gov, or by contacting the Caregiver Support Line toll-free at 1–855–260–3274.

The FY 2020 Budget for the Caregivers Support Program is $720 million, $150 million of which is specifically requested to implement the program's expansion because of the MISSION Act.

Telehealth. VA is a leader in providing telehealth services. 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 one million video telehealth visits in FY 2018, a 19 percent increase in video telehealth visits over the prior year. Telehealth is a critical tool to ensure Veterans, especially rural Veterans, can access health care when and where

they need it. With the support of Congress, VA has an opportunity to continue shaping the future of health care with cutting-edge technology providing convenient, accessible, high-quality care to Veterans. The FY 2020 Budget includes $1.1 billion for telehealth services, a $105 million or 10.5 percent increase over the 2019 current estimate.

Section 151 of the MISSION Act strengthens VA's ability to provide even more telehealth services because it statutorily authorizes VA providers to practice telehealth at any location in any State, regardless of where the provider is licensed. VA's telehealth program enhances customer service by increasing Veterans' access to VA care, while lessening travel burdens.

In FY 2018, more than 782,000 Veterans (or 13 percent of Veterans obtaining care at VA) had one or more telehealth episodes of care, totaling 2.29 million telehealth episodes of care. Of these 782,000 Veterans using telehealth, 45 percent live in rural areas. VA's major expansion for telehealth and telemental health over the next five years, for both urban and rural Veterans, will focus on care in or near the Veteran's home. VA's target is to increase Veterans receiving some care through telehealth from 13 percent to 20 percent using telehealth innovations like the VA Video Connect (VVC) application, which enables private encrypted video telehealth services from almost any mobile device or computer. VVC will be integrated into VA clinicians' routine operations to provide Veterans another option for connecting with their care teams.

Strengthening VA's Workforce. Recruitment and retention are critical to ensuring that VA has the right doctors, nurses, clinicians, specialists and technicians to provide the care that Veterans need. The FY 2020 Budget strengthens VHA's workforce by providing funding for 342,647 FTE, an increase of 13,066 over 2019. VA is also actively implementing MISSION Act authorities that increased VA's ability to recruit and retain the best medical providers by expanding existing loan repayment and clinical scholarship programs; it also established the authority to create several new programs focused on medical school students and recent graduates. VA is also implementing additional initiatives to enhance VA's workforce, such as the expanded utilization of peer specialists and medical scribes.

Business Transformation

Business transformation is essential if we are 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. The Office of Enterprise Integration (OEI) is charged with coordination for these efforts.

Office of Enterprise Integration. The scale and criticality of the initiatives underway at VA require management discipline and strong governance. As part of OEI's coordination role in VA's business transformation efforts, we have implemented a consistent governance process to review progress against anticipated milestones, timelines, and budget. This process supports continuous alignment with objectives and identifies risks and impediments prior to their realization.

For example, our VA Modernization Board recently initiated a leadership integration forum to synchronize deployment schedules across three major enterprise initiatives: adoption of Defense Medical Logistics Standard Support (DMLSS), financial management business transformation, and our new electronic health record. This forum allowed us to assess the feasibility of a concurrent deployment and identify an alternate course of action. By implementing strong governance and oversight, we are increasing accountability and transparency of our most critical initiatives.

Appeals Modernization. The Veterans Appeals Improvement and Modernization Act of 2017 (AMA) was signed into law on August 23, 2017 and took effect on February 19, 2019. The Appeals Modernization Act transforms VA's complex and lengthy appeals process into one that is simple, timely, and fair to Veterans and ultimately gives Veterans choice and control over how to handle their claims and appeals.

The FY 2020 request of $182 million for the Board of Veterans' Appeals (the Board) is $7.3 million above the FY 2019 enacted budget and will sustain the 1,125 FTE who will adjudicate and process legacy appeals while implementing the Appeals Improvement and Modernization Act. The Board continues to demonstrate its commitment to reducing legacy appeals and decided a historic number of appeals - 85,288—in FY 2018, the highest number for any fiscal year. The Board is on pace to decide over 90,000 appeals in 2019.

To ensure smooth implementation, the Board launched an aggressive workforce plan to recruit, hire, and train new employees in FY 2018. The Board on-boarded

approximately 242 new hires, including 217 attorneys/law clerks and approximately 20 administrative personnel.

The new appeals process features three decision-review lanes:

1. Higher-Level Review Lane: A senior-level claims processor at a VA regional office will conduct a new look at a previous decision based on the evidence of record. Reviewers can overturn previous decisions based on a difference of opinion or return a decision for correction. VBA has a 125-day average processing goal for decisions issued in this lane.
2. Supplemental Claim Lane: Veterans can submit new and relevant evidence to support their claim, and a claims processor at a VA regional office will assist in developing evidence. VBA has a 125-day average processing goal for decisions issued in this lane.
3. Appeal Lane: Veterans who choose to appeal a decision directly to the Board of Veterans' Appeals (Board) may request direct review of the evidence the regional office reviewed, submit additional evidence, or have a hearing. The Board has a 365-day average processing time goal for appeals in which the Veteran does not submit evidence or request a hearing.

In addition to focusing on implementation of the Appeals Modernization Act, addressing pending legacy appeals will continue to be a priority for VBA and the Board in FY 2019. VBA's efforts have resulted in appeals actions that have exceeded projections for fiscal year to date 2019. VBA plans to eliminate completely its legacy, non-remand appeals inventory in FY 2020 and significantly reduce its legacy remand inventory in FY 2020.

Finally, VBA is also undertaking a similar, multi-pronged approach to modernize its appeals process through increased resources, technology, process improvements, and increased efficiencies. VBA's compensation and pension appeals program is supported by 2,100 FTEs. VBA added 605 FTEs in FY 2019 to process legacy appeals and decision reviews in the modernized process. As of October 1, 2018, to best maximize its resources an enable efficiencies, VBA centralized these assets to conduct higher-level reviews at two Decision Review Operation Centers (DROC). VBA will convert the current Appeals Resource Center in Washington, DC, into a third DROC using existing assets.

Forever GI Bill. Since the passage of the Harry W. Colmery Veterans Educational Assistance Act of August 16, 2017, VA has implemented 28 of the law's 34 provisions. Twenty-two of the law's 34 provisions require significant changes to VA information technology systems, and VA has 202 temporary employees in the field to support this additional workload.

Sections 107 and 501 of the law change the way VA pays monthly housing stipends for GI Bill recipients, and VA is committed to providing a solution that is reliable, efficient and effective. Pending the deployment of a technology-based solution, Veterans and schools will continue to receive GI Bill benefit payments as normal. By asking schools to hold fall enrollments through the summer and not meeting the implementation date for the IT solutions of Sections 107 and 501, some beneficiaries experienced delayed and incorrect payments.

In accordance with the Forever GI Bill Housing Payment Fulfillment Act of 2018, VA established a Tiger Team tasked to resolve issues with implementing sections 107 and 501 of the Forever GI Bill. This month we awarded a new contract that we believe will provide the right solution for implementing Sections 107 and 501. By December 2019, we will have Sections 107 and 501 fully implemented. By spring 2020, all enrollments will be processed according to the Colmery Act. We will recalculate benefits based on where Veterans take classes, and we will work with schools to make Sections 107 and 501 payments retroactive to the first day of August 2018, the effective date.

The Department is committed to making sure every Post-9/11 GI Bill beneficiary is made whole based on the rates established under the Forever GI Bill, and we are actively working to make that happen. We got the word out to Veterans, beneficiaries, schools, VSOs, and other stakeholders that any Veteran who is in a financial hardship due to a late or delayed GI Bill payment should contact us immediately.

In December 2018, we updated the housing rates like we normally would have in August. Those rates were effective for all payments after January 1, 2019. Additionally, we processed over 450,000 rate corrections, ensuring that any beneficiary who was underpaid from August through December received a check for the difference. We have completed the spring peak enrollment season without any significant challenges. We worked with schools to get enrollments submitted as quickly as possible.

As VA moves forward with implementation, we will continue to regularly update our Veteran students and their institutions of learning on our progress and what to expect. Already, VA has modified its definition of "campus" to better align itself with statutory requirements, and in doing so has lessened the administrative burden on schools to report to VA housing data.

Information Technology Modernization. The FY 2020 budget request of $4.343 billion continues VA's investment in the Office of Information Technology (OIT) modernization effort, enabling VA to streamline efforts to operate more effectively and decrease our spending while increasing the services we provide. The budget allows OIT to deliver available, adaptable, secure, and cost-effective technology services to VA-transforming the Department into an innovative, twenty first century organization-and to act as a steward for all VA's IT assets and resources. 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 $401 million funds for development will be dedicated to mission critical areas, continued divestiture of legacy systems such as the Benefits Delivery Network and the Burial Operations Support System, and initiatives that are directly Veteran-facing. Funds will continue to support Veteran focused initiatives such as Mental Health, MISSION Act and Community Care, and the continued transition from the legacy Financial Management System (FMS) to the new Integrated Financial and Acquisition Management System (iFAMS). The Budget also invests $379 million for information security to protect Veterans' information.

Financial Management Business Transformation (FMBT). As mentioned above, a critical system that will touch the delivery of all health and benefits is our new financial and acquisition management system, iFAMS. In support of the Financial Management Business Transformation (FMBT) program, the FY 2020 budget requests $66 million in IT funds, $107 million in Franchise Fund Service Level Agreement (SLA) funding from the Administrations and other Staff Offices to be paid to the Financial Services Center (FSC), and General Administration funding of $11.9 million.

Through the FMBT program, VA is working to implement an enterprise-wide financial and acquisition management system in partnership with our service provider, CGI Federal Inc. VA will utilize a cloud hosted solution, configured for VA, leveraging CGI's Software as a Service (SaaS) model. VA will gain increased operational efficiency, productivity, reporting capability, and flexibility from a modern Enterprise Resource Planning (ERP) cloud solution. The new cloud solution will also provide additional security, storage, and scalability.

Infrastructure Improvements and Streamlining. I want to thank Congress for providing $2 billion in additional funding for VA infrastructure in 2019. This additional funding for minor construction, seismic corrections, and non-recurring maintenance will enhance our ability to address infrastructure needs. In FY 2020, VA will continue improving its infrastructure while transforming our health care system to an integrated network to serve Veterans. This budget allows for the expansion of health care, burial and benefits services where needed most. The request includes $1.235 billion in Major Construction funding, as well as $399 million in Minor Construction to fund VA's highest priority infrastructure projects. These funding levels are consistent with our requests in recent years.

Major and Minor Construction

This funding supports major medical facility projects including providing the final funding required to complete these projects: New York, NY - Manhattan VAMC Flood Recovery, Bay Pines, FL - Inpatient/Outpatient Improvements, San Juan, PR - Seismic Corrections, Building 1; and Louisville, KY - New Medical Facility. The request also includes continued funding for ongoing major medical projects at San Diego, CA - Spinal Cord Injury and Seismic Corrections, Reno, NV - Correct Seismic Deficiencies and Expand Clinical Services Building, West Los Angeles, CA - Site utilities for Build New Critical Care Center, and Alameda, CA - Outpatient Clinic & National Cemetery.

The 2020 request includes additional funding for the completion of the new cemetery at Western New York Cemetery (Elmira, NY) and the replacement of the cemetery at Bayamon, PR (Morovis), and expansion project at Riverside, CA. The national cemetery expansion and improvement projects at Houston and Dallas, TX and Massachusetts (Bourne, MA) are also provided for. The FY 2020 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 $399 million in minor construction funds that will used to expand health care, burial and benefits services for Veterans. The minor construction request includes funding for 131 newly identified projects as well as existing partially funded projects.

Leasing

VA is also requesting authorization of seven major medical leases in 2020 to ensure access to health care is available in those areas. These leases include new leases totaling $33 million in Colombia, MO and Salt Lake City, UT as well as replacement leases totaling $104 million in Baltimore, MD; Atlanta, GA; Harlingen, TX; Jacksonville, NC; and Prince George's County, MD. VA is requesting funding of $919 million to support ongoing leases and delivery of additional leased facilities during the year.

Repurposing or Disposing Vacant Facilities

To maximize resources for Veterans, VA repurposed or disposed of 175 of the 430 vacant or mostly vacant buildings since June 2017. Due diligence efforts (environmental/historic) for the remaining buildings are substantially complete, allowing them to proceed through the final disposal or reuse process.

Suicide Prevention

Suicide is a national public health issue that affects all Americans, and the health and well-being of our nation's Veterans is VA's top priority. Twenty (20) Veterans, active-duty Servicemembers, and non-activated Guard or Reserve members die by suicide on average each day, and of those 20, 14 had not been in our care. That is why we are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support. The FY 2020 Budget requests $9.4 billion for mental health services, a $426 million increase over 2019. The Budget specifically invests $222 million for suicide prevention programming, a $15.6 million increase over the 2019 enacted level. The request funds over 15.8 million mental health outpatient visits, an increase of nearly 78,000 visits over the 2019 estimate. This builds on VA's current efforts. VA has hired more than 3,900 new mental health providers yielding a net increase in VA mental health staff of over 1,000 providers since July 2017. Nationally, in the first quarter of 2019, 90 percent of new patients completed an appointment in a mental health clinic within 30 days of scheduling an appointment, and 96.8 percent of established patients completed a mental health appointment within 30 days of the day they requested.

Preventing Veteran suicide requires closer collaboration between VA, DoD, and the Department of Homeland Security (DHS). On January 9, 2018, President Trump signed an Executive Order (13822) titled, "Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life." This Executive Order directs DoD, VA, and DHS to develop a Joint Action Plan that describes concrete actions to provide access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following their discharge, separation, or retirement. On March 5, 2019, President Trump signed the National Roadmap to Empower Veterans and End Suicide Executive Order (13861), which creates 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.

For Servicemembers and Veterans alike, our collaboration with DoD and DHS is already increasing access to mental health and suicide prevention resources, due in large part to improved integration within VA, especially between the VBA and VHA. VBA and VHA have worked in collaboration with DoD and DHS to engage Servicemembers earlier and more consistently than we have ever done in the past. This engagement includes support to members of the National Guard, Reserves, and Coast Guard.

VA's suicide prevention efforts are guided by our National Strategy for Preventing Veteran Suicide, a long-term plan published in the summer of 2018 that provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans. It also focuses on adopting a broad public health approach to prevention, with an emphasis on comprehensive, community-based engagement.

However, VA cannot do this alone, and suicide is not solely a mental health issue. As a national problem, Veteran suicide can only be reduced and mitigated through a nationwide community-level approach that begins to solve the problems Veterans

face, such as loss of belonging, meaningful employment, and engagement with family, friends, and community.

The National Strategy for Preventing Veteran Suicide provides a blueprint for how the nation can help to tackle the critical issue of Veteran suicide and outlines strategic directions and goals that involve implementation of programming across the public health spectrum, including, but not limited to:

- Integrating and coordinating Veteran Suicide Prevention across multiple sectors and settings;
- Developing public-private partnerships and enhancing collaborations across Federal agencies;
- Implementing research informed communication efforts to prevent Veteran suicide by changing attitudes knowledge and behaviors;
- Promoting efforts to reduce access to lethal means;
- Implementation of clinical and professional practices for assessing and treating Veterans identified as being at risk for suicidal behaviors; and
- Improvement of the timeliness and usefulness of national surveillance systems relevant to preventing Veteran suicide.

Every day, more than 400 Suicide Prevention Coordinators (SPC) and their teams-located at every VA medical center-connect Veterans with care and educate the community about suicide prevention programs and resources. Through innovative screening and assessment programs such as REACH VET (Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment), VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care, which can include follow-ups for missed appointments, safety planning, and care plans.

VHA has also expanded its Veterans Crisis Line to three call centers and increased the number of Veterans served by the Readjustment Counseling Service (RCS), which provides services through the 300 Vet Centers, 80 Mobile Vet Centers (MVC), 20 Vet Center Outstations, over 960 Community Access Points and the Vet Center Call Center (877–WAR–VETS). In the last two fiscal years, clients benefiting from RCS services increased by 14 percent, and Vet Center visits for Veterans, Servicemembers, and families increased by 7 percent.

We are committed to advancing our outreach, prevention, and treatment efforts to further restore the trust of our Veterans and continue to improve access to care and support inside and outside VA.

Electronic Health Record Modernization (EHRM)

We made a historic decision to modernize our electronic health record (EHR) system to provide our nation's Veterans with seamless care as they transition from military service to Veteran status. On May 17, 2018, we awarded a ten-year contract to Cerner Government Services, Inc., to acquire the same EHR solution being deployed by DoD that allows patient data to reside in a single hosting site using a single common system to enable sharing of health information, improve care delivery and coordination, and provide clinicians with data and tools that support patient safety. The FY 2020 Budget includes $1.6 billion to continue to support VA's EHRM effort to create and implement a single longitudinal clinical health record from active duty to Veteran status, and to ensure interoperability with DoD.

The request provides necessary resources for post Go-Live activities completion of Office of Electronic Health Record Modernization's (OEHRM) three Initial Operating Capability (IOC) sites and full deployment of the remaining sites in Veterans Integrated Service Network (VISN) 20, the Pacific Northwest region. Additionally, it funds the concurrent deployment of waves comprised of sites in VISN 21 and VISN 22, the Southwest region. The solution will be deployed at VA medical centers, as well as associated clinics, Veteran centers, mobile units, and other ancillary facilities.

We are working closely with DoD to synchronize efforts as we deploy and test the new health record. We are engaging front-line staff and clinicians to identify efficiencies, hone governance, refine configurations, and standardize processes for future locations. We are committed to a timeline that balances risks, patient safety, and user adoption while also working with DoD in providing a more comprehensive, agile, and coordinated management authority to execute requirements and mitigate potential challenges and obstacles.

Throughout this effort, VA will continue to engage front-line staff and clinicians, as it is a fundamental aspect in ensuring we meet the program's goals. We have begun work with the leadership teams in place in the Pacific Northwest. OEHRM has established clinical councils from the field that will develop National workflows and serve as change agents at the local level.

Supply Chain Transformation

VA has embarked 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. We are 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 the VA to remain fully committed to providing quality health care and applying resources where they are most needed. The FY 2020 budget includes $36.8 million in IT funding to support this effort.

As we deploy an integrated health record, we are also collaborating with DoD on an enterprise-wide adoption of the Defense Medical Logistics Standard Support (DMLSS) 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 decision-making and integration required across functions, such as acquisition, logistics and construction. The DMLSS 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.

We are piloting our Supply Chain Modernization program initially at the Captain James A. Lovell Federal Health Care Center (FHCC) and VA initial EHR sites in Spokane and Seattle to analyze VA enterprise-wide application. On March 7th, 2019, we initiated the pilot kickoff at the FHCC for VA's business transformation and supply chain efforts. This decision leverages a proven system that DoD has developed, tested, and implemented. In the future, DMLSS and its technical upgrade LogiCole will better enable whole-of-government sourcing and better facilitate VA's use of DoD Medical Surgical Prime Vendor and other DoD sources, as appropriate, as the source for VA medical materiel.

Veterans Homelessness

The FY 2020 Presidents Budget (PB) continues the Administration's support of VA's Homelessness Programs, with $1.8 billion in funding, which maintains the 2019 level of funding, including $380 million for Supportive Services for Veterans Families (SSVF).

Over the past five years, VA and its federal partners have made a concerted effort to collaborate at the federal level to ensure strategic use of resources to end Veteran homelessness. Coordinated entry systems are the actualization of this coordinated effort at the local level. Coordinated entry is seen, and will continue to be seen, as the systematic approach that is needed at the community level to ensure that resources are being utilized in the most effective way possible and that every Veteran in that community is offered the resources he or she needs to end their homelessness. All homeless Veterans in a given community are impacted by the coordinated entry system given that its framework is designed to promote community-wide commitment to the goal of ending homelessness and utilizing community-wide resources (including VA resources) in the most efficient way possible for those Veterans who are in most need. This includes the prioritization of resources for those Veterans experiencing chronic, literal street homelessness. The number of Veterans experiencing homelessness in the United States has declined by nearly half since 2010. On a single night in January 2018, fewer than 40,000 Veterans were experiencing homelessness-5.4 percent fewer than in 2017.

Since 2010, over 700,000 Veterans and their family members have been permanently housed or prevented from becoming homeless. As of December 19, 2018, 69 areas-66 communities and three states-have met the benchmarks and criteria established by the United States Interagency Council on Homelessness, VA, and the Department of Housing and Urban Development to publicly announced an effective end to Veteran homelessness.

Efforts to end Veteran homelessness have greatly expanded the services available to permanently house homeless Veterans and VA offers a wide array of interventions designed to find homeless Veterans, engage them in services, find pathways to permanent housing, and prevent homelessness from occurring.

Opioid Safety & Reduction Efforts

In October 2017, the President declared the opioid crisis in our country a public health emergency. Opioid safety and reduction efforts are a Department priority, and we have responded with new strategies to rapidly combat this national issue as it affects Veterans. Success requires collaboration among VA leadership and all levels of VA staff-from medical centers to headquarters-Congress, and community

partners to ensure we are working with Veterans to achieve positive, life-changing results. The fact that opioid safety, pain care transformation, and treatment of opioid use disorder all contribute to reduction of suicide risk makes these efforts particularly important. The FY 2020 Budget includes $397 million, a $15 million increase over 2019, to reduce over-reliance on opioid analgesics for pain management and to provide safe and effective use of opioid therapy when clinically indicated.

VA's Opioid Safety Initiative has greatly reduced reliance on opioid medication for pain management, in part by reducing opioid prescribing by more than 50 percent over the past four years. Most of this progress is attributable to reductions in prescribing long-term opioid therapy by not starting Veterans with chronic, non-cancer pain on opioid therapy and, instead utilizing multimodal strategies that manage Veteran pain more effectively long-term such as acupuncture, behavioral therapy, chiropractic care, yoga, and non-opioid medications.

We are committed to providing Veteran-centric, holistic care for the management of pain and for promoting well-being. We are seeing excellent results as sites across the country deploy this "Whole Health" approach. Non-medication treatments work as well and are often better than opioids at controlling non-cancer pain. We want to assure Congress-and Veterans on opioid therapy-that Veterans' medication will not be -decreased or stopped without their knowledge, engagement, and a thoughtful discussion of accessible alternatives. Our goal is to make sure every Veteran has the best function, quality of life, and pain control.

Women's Health

VA has made significant progress serving women Veterans in recent years. We now provide full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. The FY 2020 Budget requests $547 million for gender specific women Veterans' health care, a $42 million increase over 2019.

The number of women Veterans using VHA services has tripled since 2000, growing from nearly 160,000 to over 500,000 today. To accommodate the rapid growth, VHA has expanded services and sites of care across the country. VA now has at least two Women's Heath Primary Care Provider (WH–PCP) at all of VA's health care systems. In addition, 91 percent of community-based outpatient clinics (CBOCs) have a WH–PCP in place. VHA now has gynecologists on site at 133 sites and mammography on site at 65 locations. For severely injured Veterans, we also now offer in vitro fertilization services through care in the community and reimbursement of adoption costs.

VHA is in the process of training additional providers so every woman Veteran has an opportunity to receive primary care from a WH–PCP. Since 2008, 5,800 providers have been trained in women's health. In fiscal year 2018, 968 Primary Care and Emergency Care Providers were trained in local and national trainings. VA has also developed a mobile women's health training for rural VA sites to better serve rural women Veterans, who make up 26 percent of women Veterans. This budget will also continue to support a fulltime Women Veterans Program Manager at every VHA health care system who is tasked with advocating for the health care needs of women Veterans.

VA is at the forefront of information technology for women's health and is redesigning its electronic medical record to track breast and reproductive health care. Quality measures show that women Veterans who receive care from VA are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike some other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management. We are also factoring care for women Veterans into the design of new VA facilities and using new technologies, including social media, to reach women Veterans and their families. We are proud of our care for women Veterans and are working to increase the trust and knowledge of VA services of women Veterans, so they choose VA for benefits and services.

National Cemetery Administration (NCA)

The President's FY 2020 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 FY 2020 Budget includes $329 million for NCA's operations and maintenance account, an increase of $13.2 million (4.2 percent) over the FY 2019 level. This request will fund the 2,008 Full-Time Equivalent (FTE) employees needed to meet NCA's increasing workload and expansion of services, while maintaining our reputation as a world-class service provider. In FY

2020, NCA will inter an estimated 137,000 Veterans and eligible family members and care for over 3.9 million gravesites. NCA will continue to memorialize Veterans by providing 383,570 headstones and markers, distributing 634,000 Presidential Memorial Certificates, and expanding the Veterans Legacy Program to communities across the country to increase awareness of Veteran service and sacrifice.

VA is committed to investing in NCA's infrastructure, particularly to keep existing national cemeteries open and to construct new cemeteries consistent with burial policies approved by Congress. NCA is amid the largest expansion of the cemetery system since the Civil War. By 2022, NCA will establish 18 new national cemeteries across the country, including rural and urban locations. The FY 2020 request also includes $172 million in major construction funds for three gravesite expansion projects (Houston and Dallas, TX and Bourne, MA) and additional funding for the replacement cemetery in Bayamon, PR, the gravesite expansion project in Riverside, CA, and the new national cemetery in Western NY. The Budget 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 FY 2020 Budget requests direct appropriations for the Office of Accountability and Whistleblower Protection (OAWP) for the first time since it was established. The total request for OAWP in FY 2020 is $22.2 million, which is $4.5 million, or 25 percent higher than the 2019 funding level. This funding level demonstrates VA's commitment to improving the performance and accountability of our senior executives through thorough, timely, and unbiased investigations of all allegations and concerns. This funding level will also enable OAWP to continue to provide protection of valued whistleblowers against retaliation for their disclosures under the whistleblower protections provisions of 38 U.S.C. § 714. In FY 2018, OAWP assessed 2,241 submissions, conducted 133 OAWP investigations, and monitored over 1,000 referred investigations. 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 FY 2020 budget also requests $207 million, a $15 million increase over 2019, and 1,000 FTE for the Office of Inspector General (OIG) to fulfill statutory oversight requirements and sustain the investments made in people, facilities, and technology during the last three years. The 2020 budget supports FTE targets envisioned under a multi-year effort to grow the OIG to a size that is more appropriate for overseeing the Department's steadily rising spending on new complex systems and initiatives. The 2020 budget request will also provide sufficient resources for the OIG to continue to timely and effectively address the increased number of reviews and reports mandated through statute.

Conclusion

Thank you for the opportunity to appear before you today to address our FY 2020 budget and FY 2021 AA budget request. VA has shown demonstrable improvement over the last several months. The resources requested in this budget will ensure VA remains on track to meet Congressional intent to implement the 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 and adaptive and delivers on our promises to America's Veterans.

Thank you.

Prepared Statement of Joy Ilem

JOINT STATEMENT OF THE CO–AUTHORS OF THE INDEPENDENT BUDGET: DISABLED AMERICAN VETERANS, PARALYZED VETERANS OF AMERICA, VETERANS OF FOREIGN WARS

"The President's Fiscal Year 2020 Budget Request for the Department of Veterans Affairs"

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 funding request for the Department of Veterans Affairs (VA) for Fiscal Year (FY) 2020, including advance appropriations for FY 2021.

In February, prior to the Administration's budget request, the IB released our comprehensive VA budget recommendations for all discretionary programs for FY 2020, as well as advance appropriations for FY 2021. [1] The recommendations include funding to implement the VA MISSION Act of 2018 (P.L. 115–182) and other reform efforts. After reviewing the Administration's budget request for VA and comparing it to the IB recommendations, particularly in light of the requirements of the VA MISSON Act, we believe that the request falls short of meeting the needs of veterans seeking care through VA. Although the budget request provides a seven percent increase in the level of discretionary funding, when factoring in VA's own estimates of the cost of implementing the VA MISSION Act, the shift of $5.5 billion from mandatory to discretionary funding from the Choice program, and the increased cost for providing medical care due to inflation and other factors, VA will not have sufficient resources to meet the health care needs of America's veterans.

The Administration's request of $84 billion for Medical Care is $4 billion less than the IB estimates is necessary to fully meet the demand by veterans for health care during the fiscal year. For FY 2020, the IB recommends approximately $88.1 billion in total medical care funding and approximately $90.8 billion for FY 2021. This recommendation reflects the necessary adjustments to the baseline for all Medical Care program funding in the preceding fiscal year, and assumes the Choice program is fully replaced at the beginning of FY 2020 by the Veterans Community Care Program (VCCP).

For FY 2020, the IB recommends $56.1 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 2.1 percent increase for pay and benefits across the board for all VA employees in FY 2020.

Our estimate of growth in patient workload is based on a projected increase of approximately 90,000 new unique patients. These patients include priority group 1-8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $1.3 billion.

The IB believes there are additional projected medical program funding needs for VA totaling over $1.2 billion. Specifically, we believe there is a real need for funding to address an array of issues in VA's Long-Term Services and Supports (LTSS) program, including the shortfall in non-institutional services due to the unremitting waitlist for home and community-based services; to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's Prosthetics and Sensory Aids Service); funding to expand and improve services for women veterans; funding to support the recently approved authority for reproductive services, to include in vitro fertilization (IVF); and initial funding to implement extending comprehensive caregiver support services to severely injured veterans of all eras.

The Administration's request for VA Medical Services of $51.4 billion is approximately $4.7 billion below the IB recommendation. To better understand the shortfall, it should be noted that the IB does not include anticipated receipts from VA's Medical Care Collections Fund in its recommendation. Although the Administration's request reflects an apparent increase of three percent, 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 apparent increase will ultimately result in a shortfall.

Of great concern to our members, the Administration's budget request estimates that VA will fail to meet the VA MISSION Act's very clear timetable for expanding its comprehensive caregiver support program to severely injured World War II, Korean War, and Vietnam War veterans and their family caregivers. Although we were pleased to hear at the Senate Committee on Veterans' Affairs hearing this past week that VA is still aiming to certify expansion by the October 1, 2019, deadline, we still have concerns as to whether VA will truly be able to meet the deadline, particularly in light of conflicting messages from VA and recent history in delayed

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

implementation of IT solutions for this program. These men and women have waited nearly a decade for equal treatment and it is simply unacceptable to ask them to wait longer.

As this Committee is aware, the VA Caregiver Support Program currently uses the IT system known as the Caregiver Application Tracker (CAT), which was rapidly developed due to time constraints on implementing the program and was not designed to manage a high volume of information as is required today. We are aware VA has requested a reprogramming of nearly $96 million in Medical Care funding to the IT Systems account, which includes just over $4 million to continue development and stabilization of CAT, while in its FY 2020 budget submission, VA is requesting $2.6 million to update the Caregivers Tool (CareT) to support the first phase of expansion. As this Committee is aware, VA notified Congress in April 2017 that CareT, which at that time was expected to fully automate the application and stipend delivery process for the program, experienced significant delays associated with external dependencies and lost prioritization among competing projects. As a result, a new contract had to be drafted to continue work pushing the delivery of CareT out one year to June 2018. Today, while the estimated certification date of CareT remains uncertain, there are important budgetary implications based on when certification occurs and phase one of the expansion begins, with full expectation that VA will issue interim final rules to expedite the process.

In terms of funding, the Administration included $150 million to expand VA's comprehensive caregiver program, which is over $100 million less than the IB recommendation of $253 million to fully implement phase one of the caregiver expansion in FY 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.

For Medical Community Care, the IB recommends $18.1 billion for FY 2020, which includes the growth in current services, estimated spending under the Choice program, and additional obligations under the VA MISSION Act of $3.7 billion. The Administration's FY 2020 request for $15.3 billion in discretionary funding appears to be a $5.9 billion increase in funding for Community Care. However, VA has indicated that $5.5 billion of that increase merely represents shifting $5.5 billion that would otherwise be necessary to pay for the Choice program, from mandatory funding. Considering that VA estimated the VA MISSION Act will require $2.6 billion in new funding for expanded access based on new access standards, expanded transplant care, and $271 million for urgent care, there appears to be a significant shortfall for VA community care programs.

Furthermore, during VA's budget briefing on March 11, VHA officials stated that there would be no Medical Community Care funding required to implement the new wait time access standards, that VA would be able to fully meet those standards within VA facilities; therefore, not one veteran would get VCCP eligibility due solely to the wait time standard. However, VA has also stated that the current median wait time for primary care is 21 days, which would mean that approximately half of all veterans seeking primary care appointments today have a greater than 20-day wait time. Yet, VA's budget request assumes that they would achieve 100 percent compliance with the wait time standard through greater efficiency and an approximate 30 percent increase in VA primary care providers. We have serious doubts about whether this is realistic given the national shortage of primary care providers and the time needed to recruit, hire, and onboard new employees; and certainly, whether it is achievable by the first day of the next fiscal year, just over six months from today.

The Administration's FY 2020 request for VA's construction programs of $1.8 billion dollars is a 44 percent reduction from FY 2019 funding levels, and a deeply disappointing retreat in funding to maintain VA's aging infrastructure. At the Senate Veterans' Affairs Committee hearing on March 26, 2019, in response to Senator Manchin's question about VA's ".44 percent 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 FY 2020 budget submission, which states that VA's, ".Long-Range SCIP plan includes 4,059 capital projects that would be necessary to close all currently-identified gaps with an estimated magnitude cost of between $62-$76 billion including activation costs." [Volume IV, FY 2020 Congressional Submission, Page 8.2- 47]. However, VA's FY 2020 budget request for Major & Minor Construction combined is just over $1.6 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.

For major construction in FY 2019, VA requested and Congress appropriated a significant increase in funding for major construction projects- an approximate $700 million increase. While these funds will allow VA to begin construction on key projects, many other previously funded sites still lack the funding for completion. Some of these 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 recommended $2.78 billion in major construction, nearly $1 billion more than VA's total construction request.

To ensure VA funding keeps pace with all current and future minor construction needs, the IB recommends Congress appropriate an additional $761 million 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. Previously, these changes fell under facilities similar to Non-Recurring Maintenance (NRM), but the IB recommends these specific modifications be under a different authority to ensure their priority.

In addition, the Administration's FY 2020 Medical Facilities request of $6.1 billion, which includes critical NRM to ensure VA facilities have the space to provide care, is a $660 million cut compared to FY 2019 levels. The IB recommends $6.6 billion for FY 2020.

The Administration's request of $762 million for Medical and Prosthetic Research is nearly $80 million below the IB recommendation of $840 million. The request represents a 2 percent cut, at a time when medical research inflation is estimated to be 2.8 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.

Overall, the IB believes that the Administration's FY 2020 budget request for VA will neither allow the Department to fully and faithfully implement the VA MISSION Act, nor will it fully meet the requirements to provide the health care, benefits, and services that veterans have earned. Below are some of the questions about VA's budget request that have not been answered.

- At its March 11 budget briefing, VA officials stated that the FY 2020 budget request was predicated on a carryover of approximately $3 billion from FY 2019 appropriations, but did not specify how much of it was unobligated. Specifically, how much "carryover" is assumed in the FY 2020 budget request that could have been used to meet veterans' health care needs? What are the specific dollar amounts being carried over and from what specific accounts, and into what accounts and for what purposes will this carryover funding be used in FY 2020?
- As discussed above, VA officials indicated that there would be zero new dollars necessary for the Medical Community Care account as a result of the new wait time access standards proposed because VA assumes it will be able to meet those standards 100 percent of the time within VA facilities. VA indicated it will do this through workload recapture, greater efficiency, and a 30 percent increase in the total number of VA primary care providers. What new initiatives will VA undertake and what are the specific increases in productivity that each will achieve? What are VA's detailed plans and projections for increasing primary care providers by 30 percent, and how will these new providers be in place at the beginning of FY 2020?
- What factors did VA consider in reaching its decision to cut research spending for the emerging field of genomics research in FY 2020 by two percent at a time when medical research inflation is estimated to be 2.8 percent?
- In the full budget documents made available on March 18, the Veterans Benefits Administration budget request seeks appropriations to support the exact same level of FTE for FY 2020 as it does in FY 2019. However, the Direct Labor estimate for the Disability Compensation program shows a decrease of 51 FTE in FY 2020. This small decrease in claims processors occurs at a time that the VA budget is projecting that number of pending claims for disability compensation will rise to over 450,000 by the end of FY 2020, almost a 50 percent increase in just the past three years. Why is VA requesting fewer claims processing staff in FY 2020 when its own data shows that the number of pending claims is rising dramatically?
- VA budget documents state that the Vocational Rehabilitation and Employment (VRE) program will meet and sustain the congressionally mandated goal of

1:125 counselor-to-client ratio. However, the latest data in the VA budget document also shows that from 2016 to 2018, the number of VRE participants fell from 173,606 to 164,355, more than a five percent decrease. During that same period, VRE's caseload also dropped from 137,097 to 125,513, an 8.4 percent decline. It would appear that VRE is able to meet the 1:125 goal by serving fewer veterans. Given how important and beneficial the VRE program is to disabled veterans-providing many of them with the ability to increase their economic independence-why are fewer veterans taking advantage of this program? Is the lack of counselors impacting veteran utilization? Has VRE instituted any new policies or practices that have deterred disabled veterans from seeking VRE services and what actions is VRE taking to increase awareness about the availability and benefits of VRE services?

Lastly, the IBVSOs strongly oppose four legislative proposals included in the budget that would reduce benefits to disabled veterans that were earned through their service:

1. 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 twenty-four years of round-down resulted in veterans and their beneficiaries losing billions of dollars.

In last year's budget request, the Administration sought legislation to round-down the computation of COLA for ten years. This would have cost beneficiaries $34.1 million in 2019, $749.2 million over five years, and $3.1 billion over ten years.

The Administration's new proposed budget for FY 2020 is seeking to round-down COLA increases from 2020 to 2024. 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 totaled, VA estimates it would cost veterans $34 million in 2020, $637 million over five years and $2 billion over ten 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.

2. Clarify Evidentiary Threshold for Ordering VA Examinations:

This proposal would increase the evidentiary threshold at which VA, under its duty to assist obligation in 38 U.S.C. § 5103A, is required to request a medical examination for compensation claims. Section 5103A(d)(2) requires VA to "treat an examination or opinion as being necessary to make a decision on a claim" if the evidence of record, "taking into consideration all information and lay or medical evidence . . . (A) contains competent evidence that the claimant has a current disability, or persistent or recurrent symptoms of disability; and (B) indicates that the disability or symptoms may be associated with the claimant's active military, naval, or air service; but (C) does not contain sufficient medical evidence for the Secretary to make a decision on the claim."

The Court of Appeals for Veterans Claims (CAVC), in McLendon v. Nicholson, 20 Vet.App. 79 (2006), determined that in disability compensation claims, VA must provide a VA medical examination when there is:

- Competent evidence of a current disability or persistent or recurrent symptoms of a disability, and
- Evidence establishing that an event, injury, or disease occurred in service or establishing certain diseases manifesting during an applicable presumptive period for which the claimant qualifies, and
- An indication that the disability or persistent or recurrent symptoms of a disability may be associated with the veteran's service or with another service-connected disability, but,
- Insufficient competent medical evidence on file for the secretary to make a decision on the claim. It notes that the requirement of (3) is a low threshold.

We oppose this proposal as it would be inherently detrimental to the VA claims process for all veterans. The Administration asserts the holdings by the CAVC, specifically in McLendon v. Nicholson, are inconsistent and too low a bar when compared to 38 U.S.C. § 5103A(d)(2). However, that is not correct. As noted above, the statutory requirements for a VA examination are consistent with the CAVC's holding. The Administration's proposed legislation would intentionally raise the bar of the VA's Duty to Assist and allow the VA to hold veterans to a much higher threshold and result in fewer examinations with more claim denials. This would lead to more Higher Level Review requests, supplemental claims, and appeals directly to the Board of Veterans' Appeals. Ultimately, this will result in an increased number of veterans never receiving the benefits they earned.

The Administration's proposal would reduce anticipated disability compensation to veterans by $233 million in 2020, $1.3 billion over five years, and $2.8 billion over ten years. We strongly oppose this attempt to limit the due process rights of veterans, particularly when the result will be billions of dollars in lost disability compensation for those who were injured or made ill in service.

3. VA Schedule for Rating Disability (VASRD) Effective Dates:

VA seeks to amend 38 U.S.C. § 1155 so that when VASRD is readjusted, such changes would apply to any new or pending claims and may include action to decrease an existing evaluation. Under section 1155, "The Secretary shall from time to time readjust this schedule of ratings in accordance with experience. However, in no event shall such a readjustment in the rating schedule cause a veteran's disability rating in effect on the effective date of the readjustment to be reduced unless an improvement in the veteran's disability is shown to have occurred."

Currently, if a diagnostic code rating criteria changes, the veteran can only be granted an increased evaluation under the old rating criteria up to the date of the change to the new rating criteria. The new rating criteria must be applied from the date of the change. The Administration's proposal would eliminate a veteran's ability to receive an increased evaluation up to the date of the change and only apply the new criteria. This proposal would have a negative impact on veterans and would clearly be in contrast to 38 C.F.R. § 3.103, which states, "Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government."

The Administration's proposed budget does not show any estimate of budgetary savings based on this legislative proposal and mentions only that it would make it easier for VA rating personnel to make decisions on veterans' claims. However, this proposal will eliminate any potential increased evaluations prior to the change of the rating criteria; thereby, lowering the earned benefit for affected disabled veterans. We oppose this proposal as it will have negative consequences on veterans.

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 38 U.S.C. § 1116 to eliminate payment of benefits to survivors and estates of deceased Nehmer class members. If a Nehmer class member, per 38 C.F.R. § 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 IBVSOs support VA's legislative proposal regarding 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 au-

thority 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 substantially increase VA's funding for FY 2020, veterans will be forced to wait longer for care, whether they seek care at VA or in the community, leaving unfulfilled the promises made to veterans in the VA MISSION Act.

Prepared Statement of Larry L. Lohmann

Chairman Takano, Ranking Member Roe, and Members of the Committee; on behalf of Brett P. Reistad, National Commander of the largest veteran service organization in the United States representing nearly 2 million members; we welcome the opportunity to comment on specific funding programs of the Department of Veterans Affairs (VA) in the federal budget.

The American Legion is a resolution-based organization directed and driven by active Legionnaires who dedicate their money, time, and resources to the continued service of veterans and their families. Our positions are guided by 100 years of advocacy and resolutions that originate at the grassroots level of the organization - local American Legion posts and veterans in every congressional district across the United States. The headquarters staff of The American Legion works daily on behalf of veterans, military personnel, and our communities through our roughly 20 national programs and thousands of outreach programs led by our posts across the country.

As VA continues to serve the veterans of this nation, it is vital the Secretary has the necessary tools and resources to ensure they receive timely, professional, and courteous service - they have earned it. The American Legion calls on this Congress to ensure that funding for VA is maintained by implementing the president's budget request. At a time when most federal agencies are experiencing a decrease in their respective budgets, the hope of The American Legion is that VA, with assistance from these critical committees, receives a much-needed increase.

Sustainability, accountability, information technology (IT) integration and updates, Electronic Health Records (EHR), facilities repair, construction, staff recruiting, and healthcare are paramount programs requiring adequate funding. In the 115th Congress, The American Legion testified on the need for increased funding for each of the aforementioned programs.

Implementing the VA MISSION Act

"The Budget fully supports implementation of the VA MISSION Act of 2018 and provides veterans greater choice on where they receive their healthcare-whether at VA or through a private healthcare provider. The Budget consolidates all veterans' community care programs into a single program, reducing bureaucracy and making it easier for veterans to navigate their healthcare needs."

-A Budget for a Better America, Trump Administration's Proposed FY 20 Budget

The 2014 VHA Wait Time Scandal in Phoenix demonstrated to the veteran community the increased need for care in the community. Veterans desiring community care after the enactment of the Choice Act increased. The American Legion supported the Choice Program when it was added as a temporary emergency measure as part of the Veterans Access, Choice Accountability Act (VACAA) of 2014 because of our firsthand experience witnessing the need across the country. [1]

In 2014, The American Legion established a dozen Veterans Crisis Command Centers (VCCCs) in affected areas (Fulton et al., 2018). VCCCs were established from Phoenix to Fayetteville and The American Legion spoke to hundreds of veterans personally affected by the scheduling problems within VA. The Choice pro-

[1] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, 38 U.S.C. 101

gram provided an immediate short-term option, and provided an opportunity to learn how veterans utilized the program. At that time, The American Legion recommended gathering as much data as possible from veterans using the program to improve the ability of VA's other existing authorities for care in the community.[2] Additionally, The American Legion supported the Veterans Choice Continuation Act, which continued the Veterans Choice Program (VCP) that was due to expire on August 7, 2017. Continuation of VCP ensured veterans within the VA healthcare system would continue to have the ability to access quality healthcare within their communities without interruption of services.

In 2018, a large percentage of veterans, many of which are proud members of The American Legion, voiced a preference to receive medical services closer to their homes. In response, Congress enacted the VA MISSION Act, a historic law that contains a number of policy priorities of The American Legion and other veteran stakeholders.[3] 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, released earlier this year, and to develop strategic plans with completed market assessments to provide care to veterans under the new VCCP.

The budget includes $8.9 billion in 2020 and $11.3 billion in 2021 for the VA Medical Care program to implement the MISSION Act, including access standards that expand Veterans' care options and reduce wait times for primary and specialty care.[4] The American Legion supports the President in adequately funding the MISSION Act to support VA's implementation of a new consolidated community care program. We offer this support recognizing the president will continue to request, Congress must continue to appropriate, and VA must continue to properly allocate sufficient funding to maintain VA's existing healthcare infrastructure. Further, our support relies on the understanding VA must expand capacity in locations where demand for care justifies additional VA infrastructure.

Ensuring Proper VA Staffing

"Each day, more than 380,000 VA employees come to work for America's Veterans. These employees have a close connection with Veterans - over 33 percent are Veterans themselves. The 2020 Budget supports an increase of 13,805 Full-Time Equivalent Employees (FTE) above the 2019 estimated level to expand access to healthcare and improve benefits delivery."

-Department of Veterans Affairs - Budget in Brief 2020

The American Legion has long expressed concern about staffing shortages at VA and Veterans Health Administration (VHA) medical facilities including physicians and medical specialist staffing. Unfortunately, no easy solutions exist for VHA to effectively and efficiently recruit and retain staff at VA healthcare facilities. It is important to understand that simply providing additional funding will not resolve the issue of staff shortages. 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 at all times.

While VA's Academic Residency Program made significant contributions in training VA healthcare professionals, upon graduation many of these healthcare professionals choose a career outside the VA healthcare system. The VA will remain unable to compete with the private sector without changes to current hiring practices. To this end, The American Legion supports legislation such as The VA Hiring Enhancement Act and initiatives such as establishing its own VA Health Professional University. Such initiatives address the shortcomings in recruitment and retention of highly qualified physicians[5] and allow VA to train their medical healthcare professionals to serve as a supplement to VA's current medical residency program.[6]

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

---

[2] Department of Veterans Affairs. "Veterans Choice Program (VCP)." Veterans Choice Program (VCP), 30 Jan. 2018, www.va.gov/COMMUNITYCARE/programs/veterans/VCP/index.asp.

[3] VA Mission Act Pub. L. No: 115–182

[4] Department of Veterans Affairs "Budget In Brief 2019." Department of Veterans Affairs (BiBs-8) www.va.gov/budget/docs/summary/fy2020VAbudgetInBrief.pdf

[5] The American Legion Resolution No. 115 (2016): Department of Veterans Affairs Recruitment and Retention

[6] American Legion Resolution No. 377: Support for Veteran Quality of Life: (Sept. 2016)

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. Currently, medical staff is primarily detailed to temporarily fill vacancies. This practice fails to incentivize the detailed professional to share best practices and teach, but rather to hold down the position until it can be filled by a permanent hire.

Prioritizes Funding for Suicide Prevention

Reducing deaths by suicide among the Nation's veterans continues to be VA's top clinical priority. The Budget provides essential resources for VA's suicide prevention programs and supports the expansion of key initiatives aimed at advancing VA's National Strategy for Preventing Veteran Suicide.

-A Budget for a Better America, Trump Administration's Proposed FY 20 Budget

Suicide prevention is a top priority of The American Legion, The Department of Veterans Affairs (VA), and the Department of Defense (DoD). Last summer, the nation's largest organization of wartime veterans published a white paper report titled, Veteran Suicide.[7] The American Legion is deeply concerned by the high suicide rate among servicemembers and veterans, which has increased substantially since 2001.[8] The suicide rate among 18–24-year-old male Iraq and Afghanistan veterans is particularly troubling, having risen nearly fivefold to an all-time high of 124 per 100,000, 10 times the national average. A spike also occurred in the suicide rate of 18–29-year-old female veterans, doubling from 5.7 per 100,000 to 11 per 100,000.[9] These increases are startling when compared to rates of other demographics of veterans, whose suicide rates have remained constant during the same time period.

VA has taken great strides to reduce veteran suicide. Of particular note, VA expanded the Veterans Crisis Line (VCL), responding to 500,000 phone calls every year, as well as thousands of electronic chats and text messages. Since its launch in 2007, through September 2018, VCL staff dispatched emergency services to callers in crisis over 93,000 times.[10]

VA also hired hundreds of Suicide Prevention Coordinators (SPCs), mental health professionals that specialize in suicide prevention. SPCs are based in VA medical centers and local community-based outpatient clinics all over the country. Over 80 percent of the SPCs are conducting five outreach activities per month for at-risk veterans.[11] These events provide opportunities for VA to connect to veterans who may have fallen through the cracks and are not currently seeking VA healthcare.

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 Departments of Defense and Veterans Affairs 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.[12] 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 signed an executive order last month establishing a new task force aimed at empowering military veterans and ending the suicide epidemic

---

[7] The American Legion . Veteran Suicide: A White Paper Report. Indianapolis: The American Legion , 2018. "Veterans Affairs & Rehabilitation Commission." (2018, July 12). www.legion.org/commissions/veterans-affairs-rehabilitation-commission

[8] U.S. Department of Veteran Affairs. Suicide Among Veterans and Other Americans 2001–2014. 2017. "Health Services Research & Development." www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18–5

[9] Id.

[10] Department of Veteran Affairs OIG. Healthcare Inspection: Evaluation of the VHA Veterans Crisis Line. 2018. Department of Veterans Affairs Office of Inspector General. "Office Of Healthcare Inspections". www.va.gov/oig/pubs/VAOIG–16–03985–181.pdf

[11] Department of Veteran Affairs OIG. Evaluation of Suicide Prevention Programs in VHA Facilities. 2017. Veterans Health Administration. (2009, June 10). Veterans Health Administration. www.va.gov/health/aboutvha.asp

[12] National Executive Committee Of The American Legion Resolution No. 20 , "Suicide Prevention Program." archive.legion.org/bitstream/handle/20.500.12203/9286/2018S020.pdf?sequence=1&isAllowed=y

among them.[13] The order, titled the "President's Roadmap to Empower Veterans and End a National Tragedy of Suicide," or (PREVENTS), will require top officials from multiple government agencies to coordinate a strategy to tackle the issue of veterans suicide and release recommendations to the president within the next 365 days. The American Legion believes this group led by Secretary Wilkie is a step forward, but we still have questions about how it will be executed and where the resources to support it will come from.

Congress must ensure sufficient resources are available for effective VA suicide prevention efforts. One death by suicide is one death too many. Funding for the aforementioned programs must be provided as well as money for new programs, including those to effectively treat individuals with previous suicide attempts, to deploy new interventions, and to identify those at higher risk of suicide. President Trump has called for a 9.5 percent increase in VA spending in 2020, up to a total of $216 billion. The American Legion appreciates the serious attention paid to this issue by the White House and urges Congress to appropriate these funds.

Provides Critical Funding for IT

"In 2020, OIT is requesting $4.343 billion, an increase of $240.0 million (5.8 percent) over the 2019 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 2020

Department of Veterans Affairs (VA) Information Technology (IT) infrastructure has been an evolving technological necessity over the past 40 plus years, sometimes leading the industry, and sometimes trailing. Leading the field in 1978, VA doctors developed an electronic solution to coordinate and catalog patients healthcare long before their private sector colleagues, who were slow to follow, while some private physicians still refuse to automate today. 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 telehealth project, Atlas. Atlas will enable remote examinations in selected American Legion posts.

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. This is the cost of doing business in a technologically advancing society. With this in mind, companies are turning to rented cloud-based resources and Software as a Service (SAS) to mitigate costs. These services have a lower up-front investment and negate the need for hardware maintenance and software upgrades in many cases.

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. The American Legion supports the continued effort by VA to update their systems. The president's Budget provides $4.3 billion for essential investments in IT to improve the online interface between the veterans and the Department. This includes an increase of more than $200 million to recapitalize aging network infrastructure, to expedite VA's transition to the cloud, and to support emerging VA MISSION Act of 2018 IT requirements.[14]

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 program capable of processing 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 seamless transition between the Department of Defense and VA.

---

[13] Exec. Order 13,861, 84 FR 8585 (2019)

[14] A Budget for a better America, Promises Kept. Taxpayers first. "Fiscal Year 2020 Budget of the U.S Government.", www.whitehouse.gov/wp-content/uploads/2019/03/budget-fy2020.pdf

Electronic Health Record Modernization (EHRM)

"The EHR is a high-priority initiative that would ensure a seamlessly integrated healthcare record between the Department of Defense and VA, by bringing all patient data into one common system."

-A Budget for a Better America, Trump Administration's Proposed FY 20 Budget

The American Legion, through resolution, has long endorsed and supported the Department of Veterans Affairs (VA) in creating a Lifetime Electronic Health Records (EHR) system. Additionally, The American Legion has encouraged both DoD and the VA to either use the same EHR system, or, at the very least, systems that were interoperable.

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 $1.6 billion as part of a multiyear effort to continue implementation of a new EHR system. The EHR is a high-priority initiative that ensures a seamlessly integrated healthcare record between the Department of Defense and VA, by bringing all patient data into one common system, as such we call on Congress to fund it accordingly.

Medical Facilities

During FY 2012, VA unveiled the Strategic Capital Investment Planning (SCIP) program. This ten-year capital construction plan was designed to address VA's most critical infrastructure needs. Through the plan, VA estimated the ten-year costs for major and minor construction projects and non-recurring maintenance would total approximately 60 billion over ten years.

The American Legion is supportive of the SCIP program which empowers facility managers and users to evaluate needs based on patient safety, utilization, and other factors. While it places the onus on these individuals to justify the need, these needs are more reflective of the actuality as observed by our members and during our visits. VA has taken this process and effectively neutered it through budget limitations thereby underfunding the accounts and delaying delivery of critical infrastructure.

While failing to meet these needs, facility managers will be forced to make do with existing aging facilities. While seemingly saving money in construction costs, VA will be expending money maintaining deteriorating facilities, paying increased utility and operational costs, and performing piecemeal renovation of properties to remain below the threshold of major or minor projects.

This is an inefficient byproduct of budgeting priorities. The reality remains that the SCIP program is unlikely to be funded at levels necessary to accomplish the ten-year plan. Therefore, this account must be increased to meet the short-term needs within the existing facilities.

Addresses Infrastructure Deficiencies

VA requests $1.2 billion for Major Construction operations, a decrease of $942 million (43 percent) over 2019 and similar substantial decreases in Minor Construction from $800 million to $399 million (50 percent).

-Department of Veterans Affairs - Budget in Brief 2020

Since 2003, The American Legion's Veterans Affairs and Rehabilitation Commission members conduct a series of site visits to VA medical facilities and regional offices. While on site, Legionnaires visit with veterans, their families, and VA administrators and employees to discuss successes, challenges, and limitations at each site. Included in these System Worth Saving (SWS) reports are observations and challenges concerning infrastructure. In the 2018 System Worth Saving report, The American Legion noted multiple infrastructure issues with a number of facilities around the country, including Fort Harrison, Montana; Manchester, New Hampshire; Denver, Colorado; and Durham, North Carolina. [15]

Unfortunately, the types of issues found in these facilities are not isolated incidents and are too often found in VA facilities all around the country. For more than 100 years, our nation's solution to care for those who have defended us has been

[15] The American Legion, 2018 System Worth Saving, www.legion.org/sites/legion.org/files/legion/publications/50VAR0718%20SWS%20Executive%20Summary.pdf

to build a network of care facilities across the country. The VA system currently boasts more than 1,750 facilities with more than 5,600 buildings.

The current process to manage this network of facilities is the Strategic Capital Investment Planning program (SCIP). SCIP identifies VA's current and projected gaps in access, utilization, condition, and safety. The SCIP planning process develops data for VA's annual budget requests. These infrastructure budget requests are divided into several VA accounts: Major Construction, Minor Construction, Non-Recurring Maintenance (NRM), Enhanced-Use Leasing, Sharing, and Other Investments and Disposal. The VA estimates costs at approximately $60 billion. [16]

The American Legion is very concerned about the lack of funding in the Major and Minor Construction accounts. Based on VA's SCIP plan, Congress underfunded these accounts and the president's budget does not propose enough. Clearly, if this underfunding continues VA will never fix its identified deficiencies within its ten-year plan. At current rates, it will take VA almost sixty years to address current deficiencies. VA currently has 24 partially funded major construction projects that need to be put on a clear path to completion and numerous additional projects that are in the design phase and have already received large expenditures in planning time, resources, and fees.

The American Legion also understands there is a discussion to refer to SCIP in the future as a "planning document" rather than an actual capital investment plan. Under this proposal, VA will still address the deficiencies identified by the SCIP process for future funding requests but rather than having an annual appropriation, SCIP will be extended to a five-year appropriation, similar to the appropriation process used by the Department of Defense as its construction model. Such a plan will have huge implications on VA's ability to prioritize or make changes as to design or project specifications of its construction projects. The American Legion is against this five-year appropriation model and recommends Congress continue funding VA's construction needs on an annual appropriations basis.

The American Legion recommends Congress adopt the 10-year action plan created by the SCIP process. Congress must appropriate sufficient funds to pay for needed VA construction projects and stop underfunding these accounts.

Modernizes the Veteran Appeals Process.

"The Budget provides sufficient resources for the Board of Veterans Appeals and the Veterans Benefits Administration to implement the Veterans Appeals Improvement and Modernization Act of 2017, a new streamlined framework that will provide quicker decisions on new veteran compensation appeals and resolve the remaining legacy appeals inventory. The new framework will provide veterans with increased options to resolve their appeals and improve the timeliness of appeals decisions."

-A Budget for a Better America, Trump Administration's Proposed FY 20 Budget

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. [17]

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 nine years to resolve the over 200,000 case backlog. [18]

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

---

[16] Fiscal Year 2020 Budget for Veterans' Programs and Fiscal Year 2021 advance Appropriations Request, 116th Cong. (2019) Secretary, Robert Wilkie

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

[18] VA Debt Management Brief, Office Of Management, "Department of Veterans Affairs Debt Management and Collections" drive.google.com/file/d/0B70—mGYT1tJETzZGWUZKYzdGXzg/view

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 earlier this year. The AMA sets forth specific elements that VA must address in its implementation. The American Legion believes working together with VA and Congress is vital to ensuring the success of the new appeals system. 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. The American Legion supports the funding in the president's budget and urges Congress to appropriate this money and use its oversight authority to make sure stakeholder voices continue to be heard.

Vocational Rehabilitation & Employment

The Vocational Rehabilitation and Employment (VR&E) Program provides comprehensive services and assistance enabling veterans with service-connected disabilities and employment handicaps to achieve maximum independence in daily living, become employable, and maintain suitable employment. After a veteran is found to be entitled to VR&E, a vocational rehabilitation counselor helps the veteran identify a suitable employment goal and determines the appropriate services necessary to achieve their goal.

Once a veteran's claim has been adjudicated through the appeals process, the next step is approval and access to utilize the VR&E program. However, if the processing rate of adjudicating claims is increased and no investment into the VR&E program is made, The American Legion fears the unintended consequence of increasing the applicant pool for VR&E without increasing support staff will cause concern.

Between FY11 and FY16, VR&E applicants rose from 65,239 to 112,115, creating increasing workloads for VR&E counselors tasked with developing employment goals and services for beneficiaries. The American Legion recognized the escalating problems associated with VR&E, and at our 2016 National Convention enacted Resolution No. 345: Support for Vocational Rehabilitation and Employment Program Hiring More Counselors and Employment Coordinators [19].

The combination of the increased output of claims and appeals without increasing the number of program counselors in the Vocational Rehabilitation and Employment program has the potential to accelerate the challenge into a crisis for veterans enrolled in the program.

The American Legion is thankful and proud to have worked closely with this committee and others in Congress to modernize the appeals process and is appreciative that the president's budget requests the funding necessary to keep up with a streamlined appeals process. We also encourage this committee to consider and take into account the impending need to increase funding for the VR&E program, so we can assist veterans in finding quality employment.

Increases Access to Burial and Memorial Benefits

"The Budget includes $329 million, a 4.2-percent increase from the 2019 enacted level, to expand veteran access to memorial benefits, deliver premier services to veterans' families, and provide perpetual care for more than 3.9 million gravesites."

-A Budget for a Better America, Trump Administration's Proposed FY 20 Budget

National Cemetery Administration (NCA)

No aspect of the VA is as critically acclaimed as the National Cemetery Administration (NCA). In the 2016 American Customer Satisfaction Index, the NCA achieved the highest ranking of any public or private organization, again. [20] 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.

One of the NCA's strategic goals is to provide reasonable access (within 75 miles of a veteran's residence) to a burial option in a national or Department of Veterans

---

[19] American Legion Resolution No. 345: archive.legion.org/bitstream/handle/123456789/5663/2016N345.pdf?sequence=1&isAllowed=y

[20] ACSI Benchmarks for U.S Federal Government 2016, ACSI Benchmark for U.S Federal Government www.theacsi.org/acsi-benchmarks-for-u-s-federal-government-2016

Affairs (VA)-funded state or tribal veterans' cemetery for 95 percent of eligible veterans. Currently, the NCA reports that they have reached 92 percent of this access standard.[21] 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 to expand existing cemetery facilities as the need arises.

While the costs of fuel, water, and contracts have risen, the NCA operations budget has not received a significant increase in the past three budgets. Unfortunately, recent audits have shown cracks beginning to appear. Due predominantly to poor contract oversight, several cemeteries inadvertently misidentified burial locations. Although only one or two were willful violations of NCA protocols, the findings demonstrate a system nearly ready to burst.

To meet the increased costs of fuel, equipment, and other resources as well as ever-increasing contract costs, The American Legion believes a small increase is necessary. In addition, we urge Congress to adequately fund the construction program to meet the burial needs of our nation's veterans.

State Cemetery Grant Program

The NCA administers a program of grants to states to assist them in establishing or improving state-operated veterans' cemeteries through VA's State Cemetery Grants Program (SCGP). Established in 1978, this program funds nearly 100% of the costs to establish a new cemetery, or expand existing facilities. For the past two budgets, this program has been budgeted $45 million to accomplish this mission.

New authority granted to VA funds Operation and Maintenance Projects at state veterans cemeteries to assist states in achieving the national shrine standards VA achieves within national cemeteries. Specifically, the new operation and maintenance grants have been targeted to help states meet VA's national shrine standards with respect to cleanliness, height, and alignment of headstones and markers, leveling of gravesites, and turf conditions. In addition, this law allowed VA to provide funding for the delivery of grants to tribal governments for Native American veterans. Yet we have not seen the allocation of funding increased to not only meet the existing needs under the construction and expansion level but also the needs from operation and maintenance and tribal nation grants. Moreover, as these cemeteries age, the $5 million limitations must be revoked to allow for better management of resources within the projects.

Better Care for Female Veterans

VA is anticipating and preparing for the increase in the number of women Veterans as well as for the accompanying complexity and longevity of their treatment needs.

-Department of Veterans Affairs - Budget in Brief 2020

In 2018, women Veterans comprised over 15 percent of active duty military forces and 19 percent of National Guard and Reserves. The number of women serving is growing, composing an increasingly large share of the military and veterans' populations.[22] Women veterans now comprise about 10 percent of the total veteran population, and more than 7 percent of the veterans using VA healthcare services.[23] The 2015 Department of Veterans Affairs Women Veterans Report not≥ed 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.[24]

VA needs to be prepared for a significant increase of younger female veterans, as those who served in the War on Terror separate from active service. Never before have so many women servicemembers been routinely assigned to combat zones. They sustain the same types of injuries as their male counterparts. The number of women enrolled in the VA system is expected to grow by 33 percent over the next three years.VA must ensure women veterans receive gender-specific healthcare to meet their needs across the entire network. The diverse population of women veterans using VA care require knowledgeable providers in women's health to deliver comprehensive primary care services, including mental health, gender-specific care,

---

[21] National Cemetery Administration. (2008, April 29). "National Cemetery Administration." www.ea.oit.va.gov/EAOIT/docs/NCA—LRP.pdf

[22] 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

[23] Id.

[24] 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

and referrals for reproductive healthcare needs. Finding ways to ensure that these veterans are welcome and receive the services they deserve is vital to The American Legion.

VA needs to develop a comprehensive health-care program for female veterans that extend beyond reproductive issues. Bills like the Deborah Sampson Act and the Women Veterans Access to Quality Care Act are a step in the right direction. Provider education needs improvement. Furthermore, as female veterans are the sole caregivers in some families, services, and benefits designed to promote independent living for combat-injured veterans must be evaluated, and needs such as child-care must be factored into the equation. Additionally, many female veterans cannot make appointments due to the lack of child-care options at VA medical centers. Since the 2011 survey, The American Legion has continued to advocate for improved delivery of timely, quality healthcare for women using VA. The American Legion is encouraged that the president's budget recognizes the need for additional funding in this critical area, and has proposed an increase of $42 million almost 8 percent over last year's authorization levels.

Medical Services

Over the past two decades, VA has dramatically transformed its medical care delivery system. Through The American Legion visits a variety of medical facilities throughout the nation during our System Worth Saving Task Force, we see firsthand this transformation and its impact on veterans in every corner of the nation.

While the quality of care remains exemplary, veteran healthcare will be inadequate if access is hampered. Today there are over 20 million veterans in the United States.[25] While 8.3 million of these veterans are enrolled in the VA healthcare system, a population that has been relatively steady in the past decade, the costs associated with caring for these veterans has escalated dramatically.

Since 2010, VA enrolment has increased from 8.3 million to over 9 million[26]. During the same period, inpatient admissions increased from 662 thousand to 764 thousand. Outpatient visits also increased from 80.2 to 109 million. Correspondingly, cost to care for these veterans increased respectively. The increase during these years is a trend that dramatically impacts the ability to care for these veterans.

While FY 2010 numbers seemingly leveled off - to only 3 percent annual growth - will adequate funding exist to meet veteran care needs? If adequate funding to meet these needs isn't appropriated, VA will be forced to either not meet patient needs or shift money from other accounts to meet the need.

Even with the opportunity for veterans from OIF/OEF to have up to 5 years of care following their active duty period, we have not seen a dramatic change in overall enrollee population. Yet The American Legion remains concerned that the population estimates are dated and not reflective of the costs. If current mandatory healthcare mandates for veterans remain and with the Vietnam Era Veterans continuing to retire and needing healthcare that may no longer be provided by their employers, VA medical care will become enticing for a veteran population that might not have utilized those services in the past.

In order to meet the increased levels of demand, even assuming that not all eligible veterans will elect to enroll for coverage, and keep pace with the cost trend identified above, there must be an increase to account for both the influx of new patients and increased costs of care.

Military and Veteran Caregiver Services

The Budget also supports the VA MISSION Act of 2018's expansion of the Caregivers program to include eligible veterans who incurred or aggravated a serious injury in the line of duty before September 11, 2001. Expansion of the Caregivers program would coincide with new information technology (IT) updates necessary to effectively manage the program.

-Department of Veterans Affairs - Budget in Brief 2020

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 authorized by this land-

[25] United States Department of Veterans Affairs, "Profile of Veterans': 2017″ www.va.gov/vetdata/docs/SpecialReports/Profile—of—Veterans—2017.pdf

[26] Department of Veterans Affairs, Veterans Health Administration, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. Prepared by the National Center for Veterans Analysis and Statistics

mark legislation included training to ensure patient safety, cash stipends to partially compensate for caregiver's time and effort, caregiver health coverage, and guaranteed periods of respite to protect against burnout.

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, either physically or mentally, in the line of duty on or after Sept. 11, 2001.

Finally, VA will begin to extend eligibility for the Program of Comprehensive Assistance for Family Caregivers to severely injured veterans of all eras, through a phased approach. First, VA must submit to Congress certification that the IT system relied upon by the program is prepared to accommodate a higher workload. Once the system is prepared, VA will begin processing applicants injured on or before May 7, 1975, in addition to those injured after September 11, 2001. Two years after this expansion, the program will accept all veterans severely injured in all eras.

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. Simply put, a veteran is a veteran! All veterans should receive the same level of benefits for equal service. As affirmed in American Legion Resolution No. 259: Extend Caregiver Benefits to Include Veterans Before September 11, 2001, The American Legion supports the expansion to include all veterans who otherwise meet the eligibility requirements. [27]

The American Legion believes that providing expanded support services and stipends to caregivers of veterans to all eras is not only possible but also budgetary feasible and the right thing to do. 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. The president's FY20 Budget requests $720 million for the Caregiver Support Program, a $213.5 million (42 percent) increase over the 2019 level, to support over 27,000 caregivers through the Caregiver Support Program. The American Legion supports this proposal.

Ensuring Quality Care to Rural Veterans

"The budget maintains the strong level of funding for rural health projects at $270 million. As a complement to telehealth, VA is committed to improving the care and access for Veterans in geographically rural areas."

-Department of Veterans Affairs - Budget in Brief 2020

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. From June 2017 to April 2018, the task force has been conducting site visits to VA medical facilities and town hall meetings to receive feedback from local veterans who utilize VA to receive their healthcare.

The Task Force, in its 18th program year, is focusing on VA's accomplishments and progress over the past decade and a half, current issues and concerns, and VA's five-year strategic plan for several program areas. These areas of focus are VA's budget, staffing, enrollment/outreach, hospital programs (e.g. mental health, intensive care unit (ICU), long-term services and support, homelessness programs) information technology and construction programs.

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 worried VA has turned a deaf ear to their concerns and is intentionally ignoring their complaints. We have seen firsthand where VA has closed intensive care departments, downgrading emergency departments to urgent care clinics, or has proposed to closed or reconfiguring hospital services under the guise of "realigning services closer to where veterans live."

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 requisite community services are meet or exceed that VA currently provides to veterans.

In addition to ensuring improvements to infrastructure in rural areas, Congress must support increased funding to support telehealth. 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

[27] American Legion Resolution No. 259 (2016): Extend Caregiver Benefits to Include Veterans Before September 11, 2001

of Veteran who received care via telehealth lived in rural areas, yet many Veterans are limited from this option due to lack of availability of reliable connectivity or technology.

The American Legion, Veterans of Foreign Wars, the U.S. Department of Veterans Affairs (VA) and Philips have partnered to bring VA healthcare to veterans through VA's "Anywhere to Anywhere" program. This program will allow veterans to be examined by a doctor in a familiar setting, their American Legion posts.

Through Project Atlas, 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. Veterans will be examined and advised in real time through face-to-face video sessions with VA medical professionals, who may be located hundreds or thousands of miles away. The program enables the "Anywhere to Anywhere" VA initiative to benefit veterans who would otherwise need to travel to receive care.

The president's proposed budget requests $1.1 billion for the total Telehealth program, an increase of $105 million above the 2019 level. In 2021, VA is requesting $1.7 billion, an increase of $623 million above the 2020 level. The American ardently supports this initiative and urges Congress to appropriate funds to bring affordable VA Healthcare to veterans in rural areas through this program.

Assisting Homeless Veterans

"VA requests $1.8 billion for homeless programs, maintaining the significant funding provided in 2019 and increasing funds by $179 million above the 2018 level, to provide the type of resources most needed where they are most needed across the country."

The American Legion strongly believes that homeless veteran programs should be granted sufficient funding to provide supportive services such as, but not limited to: outreach, healthcare, rehabilitation, case management, personal finance planning, transportation, vocational counseling, employment, and education. In that vein, we support the proposed funding in the president's budget and urge Congress to appropriate the funds.

Furthermore, The American Legion continues to place special priority on the issue of veteran homelessness. With veterans making up approximately 9% of our nation's total adult homeless population, there is plenty of reason to give this issue special attention. Along with various community partners, The American Legion remains committed to seeing VA's goal of ending veteran homelessness come to fruition. 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. We hope to see that with the expansion of assistance afforded to homeless veterans and their dependents, there will also be an increase in funding to support. We estimate that an additional $10 million annually will be sufficient to accomplish this goal.

Mental Health

Post-traumatic stress disorder and traumatic brain injury 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 4.7 percent increase in funding will provide find much-needed funding dedicated to this area. While Veterans who served in Iraq and Afghanistan make up only a small percentage 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. The need for specialized mental health services will only grow.

In July 2010, VA took significant strides towards assisting veterans suffering from PTSD. The liberalization of regulations relaxed the need for veterans to provide proof of a PTSD stressor; instead, veterans only needed to prove a "fear of hostility." Further, since 2012, VA has increased staffing of new mental health providers, made efforts to improve wait times for mental health services, and removed numerous barriers to care.

While The American Legion acknowledges advancements in this area, we also know there is significant room for improvement. From 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. Furthermore, if a veteran seeks service connection for a physical condition that manifested secondary or was aggravated by PTSD, veterans routinely are faced with a difficult journey.

VA has hired more than 3,900 new mental health providers yielding a net increase in VA mental health staff of over 1,000 providers, since July 2017. However, during that time there has been a massive influx of veterans into the system, with a growing need for psychiatric services. With over 1.5 million veterans separating from service in the past decade, nearly half have not utilized VA for treatment or evaluation. The American Legion is deeply concerned about nearly 750,000 veterans who are slipping through the cracks unable to access the healthcare system they have earned through their service.

The American Legion believes VA must focus on head injuries and mental health without sacrificing awareness and concern for other conditions afflicting servicemembers and veterans. As an immediate priority, the 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 American Legion recently published in, The Road Home, we believe VA must continue to search for the most effective treatment programs for veterans with comorbidities of PTSD, and TBI with substance use disorder (SUD) and chronic pain.[28] We should also seek to develop treatment options including Complementary and Alternative Medicine (CAM) for veterans who are newly diagnosed. Providers in VA must take care to prevent at-risk veterans from becoming dependent on alcohol or drugs used to "self-medicate."

Through Resolution No. 160 Complementary and Alternative Medicine, Congress is urged to provide oversight and funding VA for innovative, evidence-based, CAM in treating various illnesses and disabilities. The president's proposed budget requests $9.4 billion for Veterans' mental health services, an increase of $426 million (4.7 percent) above 2019. The American Legion supports this action. Additionally, The American Legion remains committed to working with the VA in any way possible to move the VA toward their goal of becoming a fully integrated paperless system.[29]

Medical Support and Compliance

The Medical Support and Compliance account consist of expenses associated with administration, oversight, and support for the operation of hospitals, clinics, nursing homes, and domiciliaries. Although few of these activities are directly related to the personal care of veterans, they are essential for quality, budget management, and safety. Without adequate funding in these accounts, facilities will be unable to meet collection goals, patient safety, and quality of care guidelines. The American Legion has been critical of programs funded by this account. We remain concerned patient safety is addressed at every level.

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. As the economy rebounds and states are pivoting towards 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 consumed. The American Legion encourages Congress to increase the funding level of this program.

Medical and Prosthetic Research

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 decade, 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.

---

[28] The Road Home American Legion, TBI/PTSD Committee www.legion.org/sites/legion.org/files/legion/publications/60VAR0818%20The%20Road%20Home%20-%20TBI–PTSD.pdf

[29] The American Legion Resolution No. 160 (2016): Complementary and Alternative Medicine

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

As far back as 2004, statistics were emerged indicating amputation rates for US troops were as much as twice that from previous wars. By January of 2007, news reports circulated noting the 500th amputee of the Iraq War. The Department of Defense's response involved the creation of Traumatic Extremity Injury and Amputation Centers of Excellence, and sites such as Walter Reed have made landmark strides in providing the most cutting-edge treatment and technology to help injured service members deal with these catastrophic injuries.

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. Ongoing care for the balance of their lives is delivered through the VA Healthcare system, and not through concentrated active duty centers.

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. If a veteran can receive a state of the artificial art limb at the new Walter Reed National Military Medical Center (WRNMC) they should be able to receive the exact same treatment when they return home to the VA Medical Center in their home community, be it in Gainesville, Battle Creek, or Fort Harrison.

American Legion contact with senior VA healthcare officials has concluded that while DoD concentrates their treatment in a small number of facilities, the VA is tasked with providing care at 152 major medical centers and over 1,700 total facilities throughout the 50 states as well as in Puerto Rico, Guam, American Samoa and the Philippines. Yet, VA officials are adamant their budget figures are sufficient to ensure a veteran can and will receive the most cutting edge care wherever they choose to seek treatment in the system.

The American Legion remains concerned about the ability to deliver this cutting edge care to our amputee veterans, as well as the ability of VA to fund and drive top research in areas of medicine related to veteran-centric disorders. There is no reason VA should not be seen at the world's leading source for medical research into veteran injuries such as amputee medicine, PTSD, and TBI.

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. The American Legion is skeptical of the reduction of funding for FY 20 from FY 19 in the president's proposed budget and urge Congress to, at a minimum, maintain funding.

Medical Care Collections Fund (MCCF)

In addition to the aforementioned accounts which are directly appropriated, medical care cost recovery collections are included when formulating the funding for VHA. Over the years, this funding has been contentious because they often include proposals for enrollment fees, increased prescription rates, and other costs billed directly to veterans. The American Legion has always ardently fought against these fees and unsubstantiated increases.

Beyond these first party fees, VHA is authorized to bill healthcare insurers for nonservice-connected care provided to veterans within the system. Other income collected into this account includes parking fees and enhanced use lease revenue. The American Legion remains concerned that the expiration of authority to continue enhanced use leases will greatly impact not only potential revenue but also delivery of care in these unique circumstances. We urge Congress to reauthorize the enhanced use lease authority with the greatest amount of flexibility allowable.

It would be unconscionable to increase this account beyond the previous levels that were not met. To do so without increasing co-payments or collection methods would be counterproductive and mere budget gimmickry. While we recognize the need to include this in the budget, The American Legion cannot condone a budget that penalizes the veteran for administrative failures.

Advance Appropriations for FY 2020

The Veterans Health Administration (VHA) manages the largest integrated health-care system in the United States, with 152 medical centers, nearly 1,400 community-based outpatient clinics, community living centers, Vet Centers and domiciliary serving more than 9 million veterans every year. The American Legion believes those veterans should receive the best care possible.

The needs of veterans continue to evolve, and VHA must ensure it is evolving to meet them. The rural veteran population is growing, and options such as telehealth medicine and clinical care must expand to better serve that population. Growing numbers of female veterans mean that a system that primarily provided for male enrollees must now evolve and adapt to meet the needs of male and female veterans, regardless whether they live in urban or rural areas.

An integrated response to mental healthcare is necessary, as the rising rates of suicide and severe post-traumatic stress disorder are greatly impacting veterans and active-duty servicemembers alike.

If veterans are going to receive the best possible care from VA, 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.

Round-Downs

In the president's proposed budget the VA seeks multiple Cost of Living Adjustment (COLA) round-downs. VA seeks to amend 38 U.S.C. §§ 1104(a) and 1303(a) to round-down COLA computations for Dependency and Indemnity Compensation (DIC) from 2020 to 2024 and amend 38 U.S.C. §§ 3015(h) and 3564 to round-down COLA computations for Education Programs from 2020 to 2029.

The American Legion, through Resolution No. 164, Oppose Lowering Cost-of-Living Adjustments, opposes these round-downs. The effect of the proposed round-down would serve as a tax on disabled veterans and their survivors, costing them money each year. Veterans and their survivors rely on their compensation for cost-of-living for essential purchases such as transportation, rent, utilities, and food. The American Legion is opposed to any COLA round-down as it will negatively impact the quality of life for our nation's veterans and their families. The Administration should not seek to balance the budget on the backs of veterans.

Conclusion

Implementing the VA MISSION Act will require more resources than have been provided through regular appropriations in FY19 and it will cause care appropriation needs by the VA for future fiscal years. MISSION Act changes how VA purchases health services for veterans from community providers, is projected to increase veterans' enrollment in the VA healthcare system, and increase veterans' utilization and reliance on VA as a direct provider of care. Any and all future funding levels must reflect this as part of the plan, not wait until VHA is in crisis.

Greater emphasis needs to be placed on VA's hiring and incentives, and if additional resources are needed to secure key providers like psychologists and physician's assistants, then VHA must be provided with the funding needed to make those critical hires. That is the long-term key to ensuring that veterans get the care they need in a timely fashion in the system that is designed to treat their unique wounds of war.

For Caregivers, older veterans' participation is unlikely to fluctuate, caregivers of older veterans likely will. Younger veterans tend to rely consistently on a spouse or a parent for care. Older veterans are less likely to have a spouse still capable of the physical demands of providing daily care. VA must be able to accommodate rotating caregivers, providing adequate and relevant training needed to sustain their veteran and maintain the caregivers own health as well.

VA must continue to research the most effective treatment programs for veterans with post-traumatic stress disorder (PTSD), military sexual trauma (MST), and Traumatic Brain Injury (TBI), as well as researching biomarkers and complementary and alternative medicine to include cannabis.

Individuals affected by homelessness should not have to choose between staying with their dependents or obtaining needed resources from a homeless shelter. Funds must be allocated to supporting veterans affected by homelessness who are also caring for others.

The American Legion thanks this committee for the opportunity to elucidate the position of the nearly 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Larry Lohmann, Senior Associate of The American Legion Legislative Division at (202) 861–2700 or llohmann@legion.org.

REFERENCES

Fulton, L. V., & Brooks, M. S. (2018). An Evaluation of Alternatives for Providing Care to Veterans. Healthcare (Basel, Switzerland), 6(3), 92. doi:10.3390/healthcare6030092

Questions For The Record

House Committee Members To: Department of Veterans Affairs (VA)

Questions for the Record from Rep. Lee

Question 1: According to the Fiscal Year 2020 President's Budget request, the Department of Veterans' Affairs is requesting $1.1 billion for telehealth services - a $105 million or 10.5 percent increase over the 2019 current estimate. How does the Department intend to use the $105 million budget increase to ensure open and competitive telehealth acquisitions and fair consideration of commercial-off-the-shelf telehealth solutions?

VA Response: Telehealth funding supports several aspects of VA's Telehealth program including providers' salaries, telehealth support staff salaries, training, implementation, evaluation, and technology acquisitions. When additional telehealth technology is needed, VA will leverage, where applicable, existing VA telehealth contract vehicles that VA established through the open and competitive Federal Acquisition Regulation process.

Questions for the Record from Rep. Cunningham

Question 1a: "Hospitals and medical clinics, like the Ralph H. Johnson VA Medical Center in my district, are facing increased instances of flooding. These events can be extremely disruptive to healthcare operations, even isolating the hospital from the community it serves and delaying emergency responders. Will the VA make funding accessible to address flooded access roads that service these medical facilities?

VA Response: Funding is available through the Non-Recurring Maintenance program to address infrastructure issues such as flooded access roads as long as the road is VA owned and operated.

Question 1b: Does the VA have a strategic plan to address increased flooding from tidal influences, precipitation, and hurricane storm surge at its medical centers across the country?"

VA Response: The Veterans Health Administration (VHA) complies with the VA Physical Security Design Manual, which was most recently revised in January 2015, for all new and existing facilities. The manual addresses both manmade and natural disasters, including hurricane surge and other natural events. The manual states that no new facilities shall be constructed in the 100-year flood plain and addresses the housing of equipment and construction materials in existing facilities that may be in the 100-year flood plain.

Questions for the Record from Rep. Cisneros

Question 1: I understand from a VSO that they are concerned about the proposed $234 million offset to standardize and enhance VA Compensation and Pension benefit programs, listed under "mandatory and Receipt Proposals" on page 130 (PDF controls) of the proposed budget. Will this proposed initiative result in the reduction of Individual Unemployability (IU) benefits or other benefits veterans depend on to make ends meet?

VA Response: The heading "Standardize and Enhance VA Compensation and Pension Benefit Programs" includes the following legislative proposals from the 2020 Budget:

Proposal Title	Cost/(Savings) to VA in FY 2020 ($ in Millions)
1) Clarify Evidentiary Threshold for Ordering VA Examinations	($233)
2) Prohibition of Entitlement to VA's IU Benefit for Individuals Serving in the Reserve Component	($7)
3) Reissue VA Benefit Payments to all Victims of Fiduciary Misuse	$6
Total Cost/(Savings)	**($234)**

Summaries of these legislative proposals can be found on pages 15–17 of Volume 1 of VA's 2020 Budget. The proposal to clarify the evidentiary threshold for ordering VA examinations would result in a savings associated with a reduction in the number of medical exams completed and would not represent a reduction in benefits to Veterans. The proposal to prohibit entitlement of IU for individuals serving in the reserve component would prohibit an individual from receiving IU while concurrently performing duties in the reserve components and receiving active service pay from such duty.

Questions for the Record from Rep. Peterson

Question 1: Mr. Secretary, I have two new, skilled-nursing veterans home project proposals in my district that will greatly benefit underserved rural veterans. One is in Bemidji and the other is in Montevideo. Each home has raised enough state and local funds to be listed under Priority Group 1.

For Fiscal Year 2019, the VA received $150 million and there were not enough funds to provide grant offers to all proposals under Priority Group One.

In your proposal for FY 2020, the VA's budget only requests $90 million for the extended care grant program.

How will you make sure that the need for these two veteran home projects in my district will be accounted for in your FY 2020 budget request?

VA Response: VA acknowledges that increase in requests for State Home construction funding; however, State Home construction grant funding must compete with other VA programs and needs for funding priorities. The process for awarding State Home construction grants is established in title 38 United States code, part 59. The statute outlines the process for prioritizing state projects and gives the highest priority to life or safety projects. These are projects to remedy a condition, or conditions, at an existing facility that have been cited as threatening to the lives or safety of one or more residents or program participants in the facility. The statute also requires that VA fund projects in the order of the list and that VA funding not exceed 65 percent of the total project cost. In this process, by law there is no flexibility or alternative financing mechanisms for awarding grant funds to states.

Question 2: Mr. Secretary, when will you let me know how these two veteran home projects rank compared to other grant requests?

VA Response: To be included on the VA priority list, initial grants applications are due to VA by April 15th of the prior fiscal year. Additionally, project budgets and certifications of state matching funds are due to VA by August 1st of the prior fiscal year. VA approves the project application and creates preliminary ranking of all state projects based on project type, application date, type of renovation, and the need for Veterans beds within the state. Life and safety projects are ranked above all others. The Fiscal Year 2020 State Veterans Home Construction Grant priority list is expected to be released by the second quarter of FY 2020.

Question 3: Mr. Secretary, will you and your department be willing to provide me with updates on your review progress for the two veteran home project proposals in Bemidji and Montevideo?

VA Response: All States are provided with updates on the status of their requests as part of the annual State Home Construction Grant priority list notification process.

Materials Submitted For The Record

Letter From Elaine Luria To: Department Of Veterans Affairs

April 1, 2019

The Honorable Robert Wilkie
Secretary
Department of Veterans Affairs
810 Vermont Avenue, N. W.
Washington, D.C. 20420

Dear Secretary Wilkie:

Thank you for your commitment while testifying before the Senate Veterans' Affairs Committee on March 26, 2019, to not recommend an appeal of the U.S. Court of Appeals for the Federal Circuit's decision in Procopio v. Wilkie. As you know, Blue Water Navy Veterans have waited decades to receive benefits for diseases related to herbicide exposure during their service in the Republic of Vietnam. The Blue Water Navy Vietnam Veterans Act, H.R. 299, enjoys broad bipartisan support as we collectively work to compensate these veterans. I applaud this step by VA toward recognizing Blue Water Navy Veterans as eligible for the same benefits as their fellow Vietnam veterans.

On February 27, 2019, you testified before the House Veterans' Affairs Committee. At that hearing, I asked whether you intended to extend Priority Group 6 VA healthcare benefits to Blue Water Navy Veterans. You replied that you assumed so. but would consult your attorneys and provide me with a complete answer. In light of your recommendation against appeal of Procopio, I am following up on a response to my question.

To reiterate, Procopio v. Wilkie detennined that a servicemember present within the 12 nautical mile territorial sea of the Republic of Vietnam between January 9, 1962, and May 7, 1975, is entitled to a presumption of herbicide exposure for purposes of VA disability benefits. Do you intend to treat this class of veterans as equally eligible for Priority Group 6 VA healthcare benefits based on service within the Repubic of Vietnam?

Please provide a response to this request by April 12, 2019. If you have questions or require additional infonnation, please contact Julie Turner, Counsel for the Subcommittee on Disability Assistance and Memorial Affairs, at 202–225–6603 or julie.turner@mail.house.gov.

Sincerely.

Elaine Luria
Chair
Subcommittee on Disability Assistance and Memorial Affairs
Committee on Veterans' Affairs

Letter From Chairman Takano and David P. Roe, Ranking Member To: Department Of Veterans Affairs

March 21, 2019

The Honorable Robert Wilkie
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

We are aware that the U.S. Digital Service (USDS) recently prepared an analysis regarding development of information technology (IT) systems to support implementation of the Community Care requirements of the Mission Act. [1] It is our understanding that USDS has prepared similar reports about other Department of Veterans Affairs (VA) systems over the last five years, including an ongoing report about implementation of systems to support the Caregiver Program.

In order to assist with the Committee's oversight of implementation of information technology at VA, we request that you provide complete and unredacted copies, including any attachments or appendices, of any USDS report, memorandum, or analysis pertaining to any VA IT systems prepared in the last five years. We also request that you disclose any ongoing analysis by USOS and the expected date of completion. We request that these reports be provided to the Committee no later than close of business on March 28, 2019.

Please provide the documents in electronic, soft-copy format. Do not alter the documents in any way, including but not limited to applications of redactions or a water mark. Only relevant documents and tangible things should be provided as part of the submission. Also provide the contact information for the individual(s) responsible for assembling the submission. This/These individual(s) shall certify and attest to the accuracy of the submission.

Thank you for your assistance. Should you have any questions about this request, please contact Sarah Garcia, Majority Staff Director, Subcommittee on Technology Modernization at sarah.garcia@mail.house.gov or Bill Mallison, Minority Staff Director, Subcommittee on Technology Modernization at william.mallison@mail.house.gov.

Sincerely,

Mark Takano, Chairman

David P. Roe, Ranking Member

Letter From Robert L. Wilkie To: Mark Takano, Chairman

March 29, 2019

The Honorable Mark Takano Chairman
Committee on Veterans' Affairs
U.S. House of Representatives Washington, DC 20515

Dear Mr. Chairman:

This is a response to your March 21, 2019, letter to the Department of Veterans Affairs (VA) requesting copies of any U.S. Digital Service (USDS) reports pertaining to VA information technology (IT) systems prepared in the last 5 years, in addition to information related to any ongoing analysis by USDS of VA IT systems and the expected date of completion. It is my understanding that USDS is a component of the Office of Management and Budget (0MB) within the Executive Office of the President. As such, your

[1] U.S. Digital Service, USDS Discovery Sprint Report Mission Act: Community Care (Mar. 1, 2019).

request for USDS reports, in addition to information related to ongoing USDS assessments, should be directed to 0 MB.

It also has come to my attention that on March 19, 2019, the Committee sent a letter to Ms. Marcy Jacobs, Executive Director of Digital Services at VA, requesting that she appear on Tuesday, April 2, 2019, before a full 'Committee oversight hearing, to testify on behalf of VA on the implementation of IT systems to support the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018. As I have expressed to you before, VA is committed to being as transparent as possible with Congress, Veterans, and the American people. However, respectfully, Ms. Jacobs is not the most appropriate witness to address theVA's IT systems.Instead, as an accommodation to the Committee's exercise of legitimate oversight responsibility on this important subject, I will make available Mr. James Gfrerer, Assistant Secretary for Information and Technology and Chief Information Officer, to answer any questions the Committee has in connection with the implementation of IT systems to support the MISSION Act when he appears on April 2, 2019, before the Full Committee.

Sincerely,

Robert L. Wilkie

○