JOINT STATEMENT OF

THE CO-AUTHORS OF *THE INDEPENDENT BUDGET*:
DISABLED AMERICAN VETERANS
PARALYZED VETERANS OF AMERICA
VETERANS OF FOREIGN WARS

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
CONCERNING FISCAL YEAR 2020 DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR THE VETERANS HEALTH ADMINISTRATION

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, 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 on the Veterans Health Administration (VHA) 2020 Budget request as it relates to mental health care, suicide prevention, community care, gender specific care, medical and prosthetic research, and construction and infrastructure.

Early in February, prior to the release of the Administration's budget request, the IB Veterans Services Organizations (VSOs) released our comprehensive VA budget recommendations for all discretionary programs for FY 2020, as well as advance appropriations recommendations for medical care accounts for FY 2021.[1] The recommendations also include funding to implement the VA MISSION Act of 2018 (P.L. 115-182) and other reform efforts. The IBVSOs believe that Congress must continue vigorous oversight of VA to ensure an accurate assessment of its true needs.

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 health care needs of veterans. Although the budget request provides a seven percent increase in the level of

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

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. The IBVSOs are concerned VA will not have sufficient resources to meet the health care needs of America's veterans.

The Administration's request of $84 billion for all Medical Care is $4 billion less than the IB estimates is necessary to fully meet veterans health care needs 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 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.

The IBVSOs believe that there are additional projected medical program funding needs for VA. Those costs total 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 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.

Legislation recently approved by the House Appropriations Committee minimizes some of the funding concerns we will address today, and we appreciate the House's efforts to provide more needed funding for VA than the President requested. The proposed FY 2020 Military Construction-Veterans Affairs bill funds VA medical care at $80.4 billion. This includes: $9.4 billion in mental health care services; $222 million in suicide prevention outreach activities; and $582 million for gender-specific care for women.

Mental Health and Suicide Prevention

The IBVSOs believe that ensuring access to timely and comprehensive mental health care services is a critical part of preventing suicide and improving the overall mental health of veterans. VA's budget submission to Congress indicates that the number of veterans receiving mental health services has almost doubled since FY 2006 (from 927,000 to 1.7 million).[2] Some of the evidence-based protocols used to address post-traumatic stress disorder and other issues may also be time-intensive, especially in a patient population that is known to have complex needs. In addition new populations of veterans, including veterans newly discharged from military service and veterans with discharges characterized as other than honorable, are gaining short-term access to VA's health care system for mental health care needs. Increases in the number of veterans served, means that VA needs sufficient resources to be able to meet the demands.

VHA also recently published its national Suicide Prevention Strategy which uses a "public health" model. While choosing this model is admirable, the IBVSOs worry that implementing the goals and monitoring systems that are necessary to assure effective programming—especially in populations of veterans who are not using VHA for care—could divert funding away from successful screening and treatment programs VHA already has in place for VA health care users. Indeed, it appears the request for Mental Health programs in FY 2020, while increasing funding for suicide prevention in mental health treatment programs and care in certain contract venues, is decreasing funding for some intensive treatment programs such as psychiatric residential rehabilitation and VA domiciliary care treatment. These programs often serve medically complex veterans with many psychosocial needs, such as homeless veterans, that are at increased risk for suicide. VA is also anticipating further reductions in the census for its acute psychiatry beds. These anticipated reductions are concerning to us as admission criteria for these beds is already limited to veterans who are a risk to themselves or others. Reducing these numbers will inhibit VA's ability to provide mental health treatment and could negate the Secretary's assurance that veterans may receive access to emergency mental health care on a "same-day" basis.

VA has many effective programs in place including its screening protocols for the often "invisible" wounds, such as PTSD, MST, substance use disorders, TBI, and suicidal ideation. This includes its primary care mental health integration models available at most larger VA primary care providers, evidence-based treatment protocols for PTSD, depression, anxiety and other common disorders, the VA crisis line, which has been used by millions of veterans and made referrals to suicide prevention coordinators and requested emergency services for thousands, and its REACH-VET program which uses clinical analytics to flag those veterans at the highest risk of suicide. VA is currently updating certain treatment protocols, including treatment for suicidal ideation, with the Department of Defense. Unfortunately, as more care shifts to private providers much of this expertise will not be available to veterans choosing (or compelled to use) care from non-VHA providers.

[2] Department of Veterans Affairs. 2020 Congressional Submission. P. VHA-63.

The IBVSOs have expressed concern that most non-VA providers have little experience treating veteran patients; therefore, it is essential they undergo training and meet quality standards (equivalent to quality requirements for VA providers) to assure they will have the necessary cultural competency and expertise to identify and appropriately treat common service-related mental health conditions. Moreover, we urge the Subcommittee to address the Administration's reduction in funding for Suicide Prevention Coordinators from $58.8 million in FY 2019 to $56.1 million in the revised request for FY 2020, as well as the resulting marginal increase for FY 2021. As more care aimed to be delivered outside in the private sector, it is critical that funding is increased for these coordinators, whose responsibilities include identifying high risk veterans, coordinating outreach, coordinating with other care providers and assuring that the care and monitoring for these veterans is intensified.

Research has contributed a great deal to the development of effective tools for mental health intervention in VA. The IBVSOs are particularly hopeful that research will continue to identify best practices such as telehealth and integrative medicine and other means of expanding access and tailored solutions for women veterans, MST survivors, and veterans with comorbid conditions, such as PTSD, TBI, and chronic pain who may begin to "self-medicate" to address conditions that are ineffectively treated by more conventional medical practices. The IBVSOs have also called for VA research into medical marijuana and its derivatives to determine if it is safe and efficacious in addressing certain conditions common to veterans.

Community Care

The *IB* recommends $18.1 billion for the Medical Community Care account 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 we estimate $4.3 billion in unobligated mandatory funds remained at the beginning of FY 2019 and 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.

VHA officials have 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.

The IBVSOs worked closely with this Subcommittee, Congress, and VA in helping to craft and enact the VA MISSION Act of 2018, and we continue to believe that – if fully and faithfully implemented – this landmark law can improve both the access to and quality of veterans health care. With the launch date mere days away, we are not fully confident that VA is ready to appropriately implement new wait and drive time access standards that will significantly enlarge access to VA's community care program.

The IBVSOs sought to engage VA on many issues through individual contacts, group briefings, and our responses through the Federal Register. Less than 30 days from the implementation of the VCCP, we are only now learning more about VA's implementation plans and IT systems. Consequently, we lack confidence in VA's ability to fully train their staff, educate veterans, and successfully launch the VCCP by the established date without sacrificing quality or producing negative outcomes. We have received no assurance of care coordination beyond the sharing of medical information, no assurance of funding or staffing to ensure veterans will be treated fairly and equally in terms of eligibility determinations, the quality of care they receive, and the timeliness of such care.

Caregiver Expansion

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. Yet during VA's briefing on its budget request for FY 2020 and 2021, staff announced CareT would likely not be certified until June of 2020.

We were pleased to hear Secretary Wilke and other VA officials announced that VA's efforts to improve and expand the Comprehensive Caregiver Program are back on track and VA is once again aiming to certify the IT system and initial expansion by the October 1 deadline. However, we have renewed concerns as to whether VA will truly be

able to meet the deadline, particularly in light of the termination of the CareT project and the acquisition of a new IT product VA has termed Caregiver Record Management Application or CARMA. It is our understanding the initial release will now be October 2019 to replace CAT and that the needed functionalities to certify program expansion could come as late as December 2019. We urge this Subcommittee work with the Subcommittee on Technology Modernization to ensure family caregivers are not delayed critical support and services any longer than is absolutely necessary due to continued delays in IT.

In terms of funding, the Administration included $150 million to expand VA's comprehensive caregiver program. This figure 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.

Women's Health (Gender-Specific Care)

Women are the fastest growing subpopulation within the military and veterans' populations presently comprising 16 percent of active-duty military forces, 19 percent of National Guard and Reserves[3] and about 10 percent of all veterans. Women, on average, are much younger than their male peers with many still in childbearing years (42% are 18-44 years old).[4] They are also more likely to have service connected disabilities[5] and greater proportions of women veterans use contract care.[6] On average, women consume more VHA health and mental health care services than men.

Women of the newest service eras are also taking on unprecedented roles in combat and other positions that expose them to the violence of war and environmental injuries which is likely to increase their utilization of VA's specialized services and rehabilitation programs such as those for post-traumatic stress and other post-deployment behavioral health conditions, traumatic brain injury and polytrauma, amputation, spinal cord injury and blindness.

VA has struggled to keep pace with the growth in women veterans' utilization of health care in VHA. The number of women veterans who use VHA for health care grew by 175 percent (nearly tripling) between 2000 and 2015.[7] VA reports it treated more than a

[3] Department of Veterans Affairs. 2020 Congressional Submission. P. VHA-157.
[4] Department of Veterans Affairs. 2020 Congressional Submission. P. VHA-155.
[5] Women's Health Services. Office of Patient Care Services. Veterans Health Administration. Department of Veterans Affairs. Sourcebook: Women Veterans in the Veterans Health Administration Vol. 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution. February 2018. P. 36.
[6] Sourcebook. P. 49.
[7] Women's Health Services. Office of Patient Care Services. Veterans Health Administration. Department of Veterans Affairs. Sourcebook: Women Veterans in the Veterans Health Administration Vol. 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution. February 2018. P. 3.

half million women (517,241) in 2018.[8] The growth in the number of women veterans' primary care encounters is even higher—300 percent between FY 2000-FY 2015.[9]

According to VHA's budget request, as of the end of FY 2018, a majority of women veterans are assigned to a women's health primary care provider (76 percent).[10] However, only a small percentage receive care in designated women's health clinics which women highly value for their communication and care coordination.[11] In FY 2005 and FY 2010 VA reported that only 12 percent of women veterans used women's health clinics and 22 percent used both women's health clinics and general primary care clinics (34 percent of the total population), but in FY 2015, 16 percent used women's health clinics and 17 percent used both women's health clinics and general primary care clinics (32 percent of the total population).[12] Women's health clinics must be staffed with specialized primary care providers in addition to adequate clinical and non-clinical support staff. Ideally these clinics should also have integrated mental health care services, including female peer support specialists and care coordinators available for the growing portion of services delivered by VA's community partners. Because these clinics require appropriate staffing levels and space, VA medical center directors must support their growth and maintenance as a high priority.

The Medical Services advanced appropriation for FY 2020 includes $546 million designated for gender-specific health care for women veterans. While we are pleased that the House Appropriations Committee's proposed $582 million, an additional $36 million above the FY 2020 baseline, the IB co-authors call on Congress to direct a total of $76 million above the FY 2020 baseline funding for the following purposes:

- Hire an additional 200 new physicians as designated women's health providers;
- Train 700 designated women's health providers through mini-residencies—including adding sites for specific women's health mini-residency training program on-site for rural communities;
- Hire 800 additional employees (new or internal transfers), to include nurses, Women Veteran Program Managers to eliminate collateral positions, Care Coordinators (for community care services, preventative screening services such as pap-smears, mammography, and maternity care and other gender-specific services), Clerks and other Support Staff; and
- Hire and provide specialized training for 100 women veteran Peer Support Specialists for placement in Primary Care clinics and Mental Health care teams to assist with more complex patients and suicide prevention efforts in high-risk patients

[8] Department of Veterans Affairs. 2020 Congressional Submission. P. VHA-156.
[9] Sourcebook. P. 56.
[10] Department of Veterans Affairs. 2020 Congressional Submission. P. VHA-155.
[11] Brunner, J. et al, Women Veterans: Patient-Rated Access to Needed Care: Patient-Centered Medical Home Principles Intertwined. Women's Health Issues 28-2 (2018) 165-171
[12] Sourcebook. P. 58

The Fiscal Year 2020 Military Construction-Veterans Affairs Funding Bill approved by the House Appropriations Committee last week raised funding for gender-specific care for women to $582 million—$40 million less than the IBVSOs recommended. Additional resources would still be needed to fund the initiatives above, as well as the expansion of ongoing pilot programs including women's only therapeutic nature retreats and child care.

Relatively small investments could ensure women veterans gain access to both of these programs which have demonstrated high rates of satisfaction.

Medical Care for Blue Water Navy Veterans

We note that the IB budget recommendation for Medical Services was released before the landmark decision on January 29th by the U.S. Court of Appeals for the Federal Circuit in Procopio v. Wilkie, which affirmed that Blue Water Navy Vietnam Veterans were exposed to Agent Orange, and are therefore entitled to additional benefits and health care eligibility. Although the Court decision has not yet been implemented, the House on Tuesday, May 14, overwhelmingly approved legislation (H.R. 299) to codify and protect the Procopio decision, and further action is expected to take place in the Senate in the coming weeks.

In anticipation of Blue Water Navy Veterans finally becoming entitled to Agent Orange benefits and health care eligibility, the Senate Military Construction and Veterans Affairs Subcommittee, at a hearing on April 30, was told by VHA Executive in Charge Dr. Richard Stone that the estimated cost for providing health care to all newly eligible Blue Water Navy Veterans could total almost $700 million per year. Therefore, the IB recommends that an additional $700 million be provided for Medical Service for FY 2020 and FY 2021 advance appropriations.

Medical and Prosthetic Research

VA's 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. It is also an important tool in VA's recruitment and retention of health care professionals and clinician-scientists to serve our nation's veterans. Fostering a spirit of research and innovation within the VA medical care system, the VA research program ensures that veterans are provided state-of-the-art medical care.

Despite documented success of VA investigators across many fields, the amount of appropriated funding for VA research since FY 2010 has lagged behind annual biomedical research inflation rates as estimated by the Department of Commerce, Bureau of Economic Analysis, and the National Institutes of Health. To avoid a stagnant overall purchasing power and for VA research to maintain current research efforts, the Medical and Prosthetic Research appropriation should have been increased in FY 2020.

Instead, the Administration's request of $762 million for Medical and Prosthetic Research was nearly $80 million below the IBVSOs recommendation of $840 million. Their figure represents a 2 percent cut, at a time when medical research inflation is estimated to be 2.8 percent. A sharp reduction here would greatly diminish VA's ability to provide the most advance treatments available to injured and ill veterans in the future, one of VA's core missions.

We were extremely pleased that the House Appropriations Committee adopted our recommended funding level of $840 million for Medical and Prosthetic Research in their FY 2020 Military Construction-VA Appropriations bill. We urge your support for this funding level.

VA Construction Programs

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, 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…"[13] However, VA's FY 2020 budget request is just over $1.6 billion, well 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.

Major and Minor Construction

Major and minor construction within the VA is funded at nearly $1.7 billion in the House Appropriation Committee's version of the Fiscal Year 2020 Military Construction-Veterans Affairs Funding Bill. In addition, $1 billion is provided in an administrative provision for seismic corrections at VA facilities nationwide ($850 million) and minor construction ($150 million). The IB recommended $2.78 billion in major construction, nearly $1 billion more than VA's total construction request. For Minor Construction, the IB recommended $761 million for minor construction projects, which can be completed faster and have a more immediate impact on services for veterans. Previously, these projects fell under facilities similar to Non-Recurring Maintenance, but the IB recommends these specific modifications be under a different authority to ensure their priority.

[13] 3 Department of Veterans Affairs, Volume IV, Construction And Long Range Plan, Congressional Submission, FY 2020 Funding and FY 2021 Advance Appropriations, Page 8.2- 47.

Non-Recurring Maintenance (NRM)

The Administration's FY 2020 Medical Facilities request of $6.1 billion, which includes critical NRM, is a $660 million cut compared to current levels. The IB recommends $6.6 billion for FY 2020, which includes nearly $400 million for NRM and leases, and to address VA research NRM needs.

Thank you for the opportunity to submit our views on the Administration's budget request for VA and critical issue affecting this nations veterans. 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.