

**FISCAL YEAR 2018 DEPARTMENT OF VETERANS  
AFFAIRS BUDGET REQUEST FOR THE VETERANS  
HEALTH ADMINISTRATION**

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**HEARING**  
BEFORE THE  
**SUBCOMMITTEE ON HEALTH**  
OF THE  
**COMMITTEE ON VETERANS' AFFAIRS**  
**U.S. HOUSE OF REPRESENTATIVES**  
**ONE HUNDRED FIFTEENTH CONGRESS**  
**FIRST SESSION**  
THURSDAY, JUNE 22, 2017

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# **FISCAL YEAR 2018 DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR THE VETERANS HEALTH ADMINISTRATION**

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**Thursday, June 22, 2017**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON VETERANS' AFFAIRS,  
SUBCOMMITTEE ON DISABILITY ASSISTANCE  
AND MEMORIAL AFFAIRS,  
*Washington, D.C.*

The Subcommittee met, pursuant to notice, at 2:03 p.m., in Room 334, Cannon House Office Building, Hon. Brad Wenstrup [Chairman of the Subcommittee] presiding.

Present: Representatives Wenstrup, Bilirakis, Radewagen, Dunn, Rutherford, Higgins, Brownley, Takano, Kuster, O'Rourke, and Correa.

Also Present: Representatives Roe and Sablan.

## **OPENING STATEMENT OF BRAD WENSTRUP, CHAIRMAN**

Mr. WENSTRUP. The Subcommittee will come to order. Before we begin, I would like to ask unanimous consent for fellow Committee Member Congressman Sablan from the Northern Mariana Islands to sit on the dais and participate in today's proceedings.

Without objection, so ordered. Thank you.

With that, good afternoon. We thank you all for joining us today to discuss the Department of Veterans Affairs fiscal year 2018 budget submission, particularly as it pertains to medical and mental health care, community care, medical and prosthetic research, construction and infrastructure, and veteran homelessness. There is certainly no shortage of topics to address this afternoon, so I will keep my opening comments short so we can devote most of our time to questions.

However, there are three points to discuss before hearing from Ranking Member Brownley and our witnesses.

First, the President's budget request includes \$186.5 billion in budget authority for VA in fiscal year 2018, an increase of \$6.4 billion over fiscal year 2017.

Some have alleged that the increased funding for the Veterans Health Administration in this budget goes primarily to community care programs, like Choice, rather than traditional in-house programs, which some claim is a dangerous step toward privatization. This is not the case. And privatization is certainly not the goal.

As the Secretary clarified in testimony before the Senate just yesterday, the increase provided to medical services in this budget is three times as large as the increase provided to community care.

Second, the elephant in the room this afternoon is the unexpected shortfall in the Choice Fund that the Secretary announced last week.

In a letter sent to the Committee on Friday evening, Secretary Shulgin wrote that higher than expected utilization of the Choice Program this year has resulted in an acceleration of funds being expended from the Veterans Choice Fund and without significant changes to current Choice processes. The Choice Fund is expected to run dry by August 15th.

There are a number of questions remaining today about the extent of the shortfall, the resources, and the actions the Secretary needs and when to address it and the consequences of inaction for veteran patients who, more than ever before, are relying on Choice to get the care that they need.

Dr. Alaigh, I am hoping that you will be able to provide some clarity this afternoon on all of those things. Finally, as the Choice Fund shortfall clearly shows, we have challenges today, problems we cannot solve without the help of our veterans service organization partners. I am grateful to Disabled American Veterans, Paralyzed Veterans of America, the Veterans of Foreign Wars, and The American Legion for agreeing to testify this afternoon.

We share a mutual sacred goal: meeting health care needs of veteran patients. We are relying on you to come to the table with actionable solutions with how we can move forward together given the fiscal realities that we all know exist. We can't hide from them.

I am grateful in advance for your candor and your cooperation, and I am very much looking forward to today's discussion.

And, with that, I will now yield to the Ranking Member Brownley for any opening statement that she may have.

#### **OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER**

Ms. BROWNLEY. Thank you, Mr. Chairman.

And thank you, Under Secretary, for being here with us today. I look forward to hearing from you on how this budget request will meet the health care needs of our Nation's veterans. I am also looking forward to testimony from the VSOs on whether or not this budget request meets the needs of their millions of veteran members.

Dr. Alaigh, as Acting Under Secretary of Health, you have taken on more in the last few months of your tenure than many prominent Under Secretaries attempt in their entire period of service. Over the last few months, VHA has committed to the acquisition of a commercial electronic health care record system, the extension of the Choice Program to utilize all of the funds Congress provided in 2014, the consolidation of capital assets, the establishment of a White House hotline, and VA's decision to drop the appeal of the Staab case.

And while these commitments and decisions seem to be necessary on their face, I question whether VHA has been realistic in their request for the funds to support these costly commitments.

I hope today that you and the VSOs here can help my colleagues and myself understand how VHA plans to successfully execute these commitments while ensuring that quality and access to VHA care is improved and not sacrificed.

Because Members of this Committee on both sides of the aisle want you to succeed and build the 21st century high-performing VHA our veterans deserve, I am especially interested in hearing more today about services and programs to improve women veterans health care. This cannot fall by the wayside.

By 2035, the population of women veterans is expected to swell to 35 percent of the total veteran population. VHA must be prepared to meet these expanding populations' needs. Women veterans deserve to receive care from professional providers in comfortable settings and in easily accessible manner. We need to keep working to break down barriers that may be preventing women veterans from receiving VA care, and I look forward to hearing from you, Doctor, and the VSOs about how we can do it better.

I am also looking forward to hearing more about other programs, including the caregiver program, the future of the VA's Care in the Community accounts, medical research, and services to address mental health and veteran suicide. While I am glad to see a general increase in the funding at VHA, we also want to hear more about some of the cuts and spending decisions included within the budget and how these could impact the care we provide to our veterans.

Dr. Alaigh, yesterday, we had an opportunity to meet and talk about some areas of concerns I have regarding the services in my district and across the country, and I appreciate the dialogue that we have had on these issues. I hope today we can continue that open dialogue and work together and with the VSOs to determine what level of funding is necessary to ensure that VHA can accomplish its full mission.

Thank you, Mr. Chairman. And I yield back the balance of my time.

Mr. WENSTRUP. Thank you.

Joining us this morning on our first and only panel is Joy Ilem, the National Legislative Director for the Disabled American Veterans; Carl Blake, the Associate Executive Director For Government Relations for the Paralyzed Veterans of America; Carlos Fuentes, the Director of the National Legislative Service for the Veterans of Foreign Wars of the United States; Matt Shuman, the Director of the Legislative Division for The American Legion; and Dr. Poonam Alaigh, the Acting Under Secretary for Health in the Veterans Health Administration in the Department of Veterans Affairs, who is accompanied by Mark Yow, who is the Chief Financial Officer for the Veterans Health Administration.

I want to thank you all for meeting here this afternoon.

Ms. Ilem, we will begin with you. You are now recognized for 5 minutes.

#### **STATEMENT OF JOY ILEM**

Ms. ILEM. Thank you, Mr. Chairman, and Members of the Subcommittee. On behalf of DAV and as one of the coauthors of the independent budget, I am pleased to present our views on the

budgetary needs for a few of VA's most critical health care programs. While DAV appreciates the increases recommended for VA in the President's budget, we are concerned they are not sufficient for VA to meet significant increased demand for care and its goals of providing timely, high-quality care for veterans both in the VA and in the community.

We applaud Secretary Shulkin for his leadership and efforts to restore veterans' trust in VA and to improve their access to care and benefits as well as his focus on reforming inefficient business practices and modernizing the Department. We know the Secretary has also set forth a number of other priorities: building a high-performing health care network, addressing capital infrastructure needs, replacement of VA's electronic health records and critical IT systems, expanding mental health services to veterans with other than honorable discharges, and the campaign to eliminate suicide in the veteran population.

While we support all of these reforms, we want there to be an honest assessment and discussion about what the real costs are for accomplishing all of these important goals.

Additionally, we ask that you reject the proposals included in the President's budget that would eliminate individual unemployability benefits and ramp down veterans' disability compensation cost-of-living adjustments for millions of service-disabled veterans.

Another important issue to veterans is timely access to VA mental health services. Veterans with serious mental health illness, post-deployment mental health challenges, including PTSD associated with combat or sexual trauma, are best served by VA's highly skilled mental health providers and a comprehensive mental health care model. These services are also critical to VA's suicide prevention efforts.

We also note the Secretary proposed opening access to mental health care for veterans in crisis who have received a less than honorable discharge. While we support this initiative, we are concerned that no additional resources have been put forth in the budget to address a potential increase in workload, hire additional providers, or expand clinical space, if necessary. We also want to ensure appropriate funding is available to improve VA care and services for women veterans.

DAV recommends an additional \$110 million for women's health programs to meet increased demand for services including coverage of gender specific care, hiring and training of women's health providers, expansion of childcare pilot and days of care for newborns, as well as renovating VA's facilities to resolve identified privacy and safety deficiencies.

Additional funding is also essential to continue research on the health effects of wartime service on women veterans and to better address the high rates of homelessness, suicide, and unique transition challenges among this population. These services are especially critical for women veterans with service-connected disabilities, women veterans with wartime service, and women who have—and veterans who have experienced sexual trauma.

Finally, we ask the Subcommittee to eliminate the inequity in the current caregiver law this year which limits essential services and supports to family caregivers of post-9/11 veterans. The limita-



tion left thousands of seriously disabled veterans' families without the level of caregiver support and services that they desperately need and deserve. It is time now to recognize the selfless service and dedication of all our caregivers by including resources in the fiscal year 2018 budget to finally resolve this inequity.

In closing, the new administration has pledged full support for our Nation's veterans and a reformed VA. Secretary Shulkin has committed to carry out that promise by creating a system that is worthy of their service and sacrifices.

As VA moves forward to rebuild trust with veterans, make needed reforms, and carry out modernization plans to strengthen and improve veterans' health care, we must ensure VA has the resources and support needed to be successful.

Mr. Chairman, that completes my statement, and I am pleased to answer any questions you may have. Thank you.

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

Mr. WENSTRUP. Thank you.

Mr. Blake, you are now recognized.

#### STATEMENT OF CARL BLAKE

Mr. BLAKE. Chairman Wenstrup, Ranking Member Brownley, Chairman Roe, and Members of the Subcommittee, on behalf of Paralyzed Veterans of America, our coauthors of the independent budget, the VFW, DAV, I would like to thank you for the opportunity to testify today.

I think I would like to begin by applauding the VA and Secretary for a number of recent decisions that he has made with regards to the IU proposal and the need to use that money to fund the Choice Program. He has said he will drop the IU proposal as a means to fund it. That is the right decision.

The Staab ruling, the decision to drop the appeal so that veterans can now get reimbursed for emergency care sought in the community, a decision in that case that is the right decision.

The decision with regard to finally coming to a linkable, interoperable solution in EHR with the Department of Defense, that looks like it is the right solution.

The decision as it relates to other than honorable discharges, it will serve veterans that need to be served; that is the right decision.

The caregiver expansion, we all in this room know what the right decision is. It is yet to be made, but it needs to be made.

Now let's think about the financial impact of those right decisions. The IU proposal alone leaves \$3.2 billion that must be addressed. You cannot be unequivocal about that: \$3.2 billion that now has to be addressed in some fashion.

The Staab ruling, that is \$2 billion in outstanding obligations from the previous 2 years, plus what will likely be an average of \$1 billion going forward under that requirement.

We don't even know yet what the EHR costs will be in the long term. There are estimates, but they vary.

The same with the other than honorable discharge.

We know that the caregiver expansion will cost significant money. That doesn't mean that it is not the right thing to do.

I have heard in the last week or two a lot of discussion about, well, VA has its collections money available, has its carryover funds available, it needs transfer authority: all of these ways that they can presumably get to fixing these problems. But let's be reminded: The IU and the Staab rulings alone are \$5 billion. I don't work in the VA, but I doubt that there is \$5 billion laying around at central office or in the business available to fill those holes.

The fact is that VA has not been fully forthcoming with what it needs for these purposes. And to keep saying, "Well, we have collections money available, we have carryover money available, just give us the transfer authority, we can make this work," that is nonsense. We have grown weary of that nonsense.

I will grant you that collections money is available, but it is already planned for some purpose in VA. It is built into VA's budget baseline. If you take that money and fill the Choice hole, what did you take it away from? There are crosswalks that might demonstrate where those are taken from, but you better be able to justify where you are taking that money from.

Carryovers, I will grant you the VA ends up with a significant amount of money that is available each year in carryovers. My understanding is some of what they have available is fenced for the hepatitis decision, and with some flexibility, they can repurpose that because they came in under cost to meet the hepatitis need.

But, you know, we often get asked the question, why the hell does the VA still have carryover money at the end of the year, particularly when it is hundreds of millions of dollars? What are they spending their money on? Or, better yet, what are they not spending their money on? I understand that they can't spend more than they are given. I fully understand that. But when the VA has hundreds of millions of dollars left in carryover every year, begs a lot of questions about how they are being efficient with their resources.

The idea that they just need the transfer authority to move money around—the Secretary has really sort of harped on this, is give us the ability to transfer money out of the medical community care account to fill in the hole on Choice. Fine. If you want to do that, fine. But I ask you, what happens to the veterans being served in that medical community care account State currently? How are you going to address their needs—or if you take it from somewhere else? A perfect snapshot of this transfer authority issue is the NRM piece of medical facilities. For years, the VA requested approximately \$500 million for NRM. I can tell you, and the VA knows, they actually spend about \$1.3 billion to \$1.4 billion a year. They actually spend that money. Where is that money coming from? What are they borrowing from to pay for that bill? What Peter are they robbing to pay Paul?

We are tired of this. The VSOs, the veterans we serve, the veterans that seek care from the VA are tired of this. It is time to just do it right. Tell us what you need, let Congress act upon it.

The Mil Con, VA Appropriations in the full Appropriations Committee just last week approved their bill to fund the VA. It is less than the administration's request. Does that sound like it is a good idea? Because I certainly don't think so.

Mr. Chairman, I would like to thank you again for the opportunity to testify. I would be happy to answer any questions you or the Members may have.

[THE PREPARED STATEMENT OF CARL BLAKE APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Mr. Blake.

Mr. Fuentes, you are now recognized for 5 minutes.

#### STATEMENT OF CARLOS FUENTES

Mr. FUENTES. Chairman Wenstrup, Ranking Member Brownley, Members of the Subcommittee, on behalf of the men and women of the VFW Auxiliary, I would like to thank you for the opportunity to present our views on VA's budget request.

The VFW is glad the administration has proposed a 6-percent increase in VA's discretionary budget. We also strongly support the Department's focus on increased access to high-quality health care for our Nation's veterans; combating veterans suicide, including partnerships with organizations like the VFW to leverage our footprints in communities around the country and the world in an effort to eliminate the stigma associated with seeking mental health care; ensuring VA is ready and able to care for women's veterans, who are the fastest growing cohort of the veterans' population; and the continued commitment to end veterans homelessness.

However, I would like to make it clear that the VFW strongly opposes efforts to claw back benefits from our most severely disabled veterans. In the past 2 weeks, more than 40,000 letters and emails from VFW members and supporters have been sent to Members of Congress opposing the administration's proposal to revoke individual unemployability benefits for veterans who are unable to work because of their service disabilities. The VFW opposes the IU and the COLA ground-down proposals in the Department's budget request. And we are glad to see Secretary Shulkin has agreed to look for other ways to fund the Choice Program.

The continued failure by Congress to eliminate sequestration has forced the administration to propose cuts to veterans programs in order to expand the Choice Program under mandatory spending instead of including the program in discretionary spending. Sequestration and Budget Control Act spending caps limit our Nation's ability to provide servicemembers, veterans, and their families the care and benefits they have earned. The VFW calls on this Subcommittee to join our campaign to end sequestration and do away with arbitrary and outdated budget caps.

For more than a decade, the IB VSOs have warned Congress and the VA that perpetual underfunding has allowed VA's infrastructure to erode while its capacity has swelled from 81 percent in 2004 to as high as 100 percent to 2012. We continue to believe that this need for space and chronic underfunding of VA's major construction projects could force VA to ration care. VA's budget request says that improving the conditions of VA facilities through major construction projects accounts for the largest resource need to keep pace with the growing demand of VA outpatient care, yet the administration's request only funds one VA major construction project.

The IB VSOs believe that VA has requested an adequate amount for major medical leases. However, Congress must find a way to quickly authorize leasing projects. There are now 27 major medical leases awaiting congressional approval. Delays in authorization of these leases have a direct impact on VA's ability to provide timely care to veterans. The VFW urges the Committee to swiftly pass legislation that would streamline the authorization process for VA's major medical leases.

Mr. Chairman, this concludes my remarks. I am happy to answer any questions that you or the Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF CARLOS FUENTES APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Mr. Fuentes.

Mr. Shuman, you are now recognized for 5 minutes.

#### **STATEMENT OF MATTHEW SHUMAN**

Mr. SHUMAN. Earlier this week, a fellow veteran called The American Legion for help. She was seeking medical care from the VA, a mammogram specifically, but the VA employee told her that the request was denied because funds from the Choice Program were depleted. Fortunately, the VA employee was wrong. Our staff contacted Dr. Baligh Yehia, the Deputy Under Secretary for Health and Community Care at the VA, to determine if the funds were available so this veteran can receive the medical diagnostics she deserved. The bad news is the Choice Program seems to confuse even VA staff. The good news is The American Legion and Dr. Baligh Yehia were able to assure the veteran got the care she needed.

Chairman Wenstrup, Ranking Member Brownley, Chairman Roe, and Members of the Subcommittee, on behalf of Charles E. Schmidt, the national commander for the largest veteran organization in the United States, representing more than 2.2 million members, we welcome this opportunity to comment on the President's proposed budget.

The American Legion has reviewed the President's budget request, and while we fully support the administration's proposal to increase the discretionary budget for the VA by \$4.3 billion, we would like to draw this Committee's attention to several components of this request that only Congress can address.

In 2014, President Obama signed the Choice Act. The American Legion supported this program as a temporary emergency measure, provided it had a sunset date. Through increased emphasis on eradicating all hidden wait lists and ensuring that all veterans asking for VA medical appointments were seen within 30 days or less, VA quickly exhausted their community care accounts while the Choice funding remained largely untouched. Because of the way Choice was funded, VA couldn't adjust the funding between their traditional contracting accounts. This created an unbalanced community care program. Then-Secretary McDonald mandated all appointments be pushed through the Choice Program to spend the money. This decision caused an artificial dependence on the Choice Program while preserving VA's more established community care program accounts.

The American Legion calls on the President and this Congress to support VA medical infrastructure by reallocating the funding proposed in the 2018 Presidential budget toward current community care programs and allowing Choice to expire.

Shifting from Choice to mental health, about one-third of returning servicemembers report mental health symptoms and suffer from major depression or post-traumatic stress disorder. Sixteen years of continuous conflict in Iraq, Afghanistan, and elsewhere has increased the demand for mental health services at VA. Unfortunately, there is a national shortage of mental health care providers, and this shortage is projected to grow over the next decade. Simply stated, there is an urgent need to respond and assist veterans in a timely and responsible manner. The American Legion calls on this President and this Congress to increase funding to eradicate mental health staffing shortages.

Focusing on medical research and IT, I think we can all agree that medical research is essential to improving the quality of care for veterans. The American Legion noticed that in the President's budget, \$18 million has been stripped out of the IT appropriation for all VA research. We are very concerned about the long-term impacts of cutting research projects like the Million Veteran Program. Few people know that the VA has built the world's largest and most robust genomic databases where medical investigators are currently studying Gulf War illness, PTSD, bipolar illness, and more.

The VA's medical research helps to advance VA health care and ensures the VA delivers world class, innovative services to veterans. A significant cut like this will negatively impact veterans.

Secretary Shulkin, in his speech made at the White House, stated he plans drastic changes to VA IT. In fact, he mentioned this may be the only area in which he asks Congress for more funds. As previously stated, The American Legion is very concerned about the long-term impacts of an \$18 million cut to the VA IT architecture, and we call the President and this Congress to fully fund medical research and modernization.

Lastly, I will quickly address some ideas to pay for the increased budget at the VA. The American Legion aggressively opposes cannibalizing existing benefits earned by veterans to support benefits for other veterans. Without question, the proposal to eliminate the individual unemployability benefit is one of the worst ideas The American Legion has heard in years. We have received many calls and emails from our members expressing alarm.

I personally spoke to a veteran who began crying as he explained to me that he would literally lose his home if his IU benefit was cut. Additionally, the President's proposed budget would also round down to the nearest dollar the annual cost-of-living adjustment. Like IU, this is a bad idea, and The American Legion opposes this. The simple reality, we should not be asking veterans to pay for their own earned benefits.

Chairman Wenstrup, Ranking Member Brownley, Chairman Roe, and Members of this Committee, it is my honor and duty to share the American Legion's analysis of the President's budget with you, and I very much look forward to answering any questions you may have. Thank you.

[THE PREPARED STATEMENT OF MATTHEW SHUMAN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you.

Dr. Alaigh, you are now recognized for 5 minutes.

**STATEMENT OF POONAM ALAIGH, M.D.**

Dr. ALAIGH. Good afternoon, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to appear before you to discuss the Veterans Health Administration's fiscal year 2018 budget submission and fiscal year 2019 medical care advanced appropriation request. I am accompanied today by Mark Yow, our CFO at VHA.

By way of introduction, I have served as a physician and a health care executive in both the private sector and the government sector for over 25 years. I have also served as a frontline physician at the VA medical center in New Jersey for over a decade.

Then, as now, I have continued to learn a great deal from my patients. My respect for the selfless men and women only grows deeper each day. I am grateful to be here in support of veterans and VHA employees. I believe that it is my personal mission, responsibility, and privilege to support them in every way that I can. Because of their sacrifices and service, I am committed to making sure veterans receive the very best care anywhere.

The 2018 budget request will allow VHA to continue on the path begun by then-Under Secretary Shulkin towards improving the timeliness and quality of care. This also fulfills the administration's strong commitment to all of our Nation's veterans by providing the resources necessary to support those who have earned this care through sacrifice and service to our country.

This budget is not designed to privatize the VA but, rather, to get the veterans the best care when and where they need it. Our goal is to make VA strong. We are committed to making VA services best in class.

Suicide prevention is our most important clinical priority at the VA, and it is critical that we make suicide prevention everybody's priority.

We have thousands of health care professionals helping save lives of veterans every day. Our veterans' crisis line continues to do amazing work. Since its inception, the VCL has answered over 2.9 million calls, dispatched priority services and rescues to over 77,000 veterans, and referred 470,000 veterans to local VA suicide prevention coordinators. We have also launched REACH VET, a program that analyzes veteran data and identifies those veterans at increased risk for suicide and hospitalization. We are also training all the staff through Operation SAVE, teaching everyone to recognize the danger signs of suicide and the steps to be taken to prevent this tragic and unnecessary death.

There are many examples of VA employees that have helped prevent a veteran suicide. For example, a VA employee saw a veteran on the ledge at the top of a VA parking garage. He looked depressed. This employee sent one of her colleagues to get the police while she calmly talked with him until they arrived and saved his life. This is just one story. We will continue to focus on these critical issues.

Another one of our priorities to which I am deeply committed is ensuring veterans have timely access to care. VA is taking steps to expand capacity at our facilities by focusing on staffing, space, and productivity. We are also increasing transparency and empowering veterans to make more informed decisions about their health care through our new access and quality tool, [accesstocare.va.gov](https://accesstocare.va.gov). This tool will instill a spirit of competition and encourage our medical facilities to proactively address access and quality issues while empowering veterans to make choices according to what works best for them and their families.

It also allows veterans to access the most transparent and easy-to-understand wait times across the VA and quality care measures across the health care industry.

We are in the process of redesigning and modernizing VHA, and this budget supports those efforts. We must recognize we must address community care access and are committed to streamlining and improving it.

A redesigned community care program will not only improve access to veterans but will also transform how VA delivers care within our facilities. Community care access must be guided by principles based on clinical need and quality. VA will continue to partner with Congress and the other stakeholders to achieve our common goal of providing the best care we can for our veterans.

Additionally, as you know, Secretary Shulkin announced that VA will start the process of adopting the same electronic health record as DoD to ensure continuity of care between the two Departments. We will incorporate the lessons learned through our pioneering work on VistA as we move forward. We will also be creating an integrated EHR product, that, by utilizing the same DoD platform, will require meaningful interface with other vendors to create a seamless system that serves the veterans in the best possible way. We believe that this product will serve as a model for the Federal Government and health care across the country.

Finally, VA is committed to providing the highest quality of care which our veterans have earned and deserve. I appreciate the hard work and dedication of all of our stakeholders. We are all committed to making VA strong, and this budget does that.

I look forward to continuing our partnership with this Subcommittee and the entire Congress and to work together to continue to enhance the delivery of health care services to our Nation's heroes. I know you share my personal commitment to make sure veterans get the very best of care.

Mr. Chairman, Members of the Subcommittee, thank you, again, for this opportunity to testify. My colleague and I are here to answer any questions.

[THE PREPARED STATEMENT OF POONAM ALAIGH, M.D., APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you all very much.

I now yield time for myself for questions.

I would like to start, Dr. Alaigh. In response, for the record, to our hiring hearing that was held in March of this year, we were told that there are currently 38,000 vacancies across VA as of April 24, 2017. That is using data from VHA's web HR system. So, when VA states that they have a certain number of vacancies, are those

positions considered funded, and by that I mean appropriated funds that are available to fill those positions? Then, if they are not expended for the position, what happens with them? Does that money gets rescinded or rolled over if not used, or is it repurposed within a particular budget line?

Dr. ALAIGH. Thank you, Mr. Chairman, for the question. Our goal at the VA is to make sure that our veterans are getting the highest quality of care with the greatest amount of access.

In this year's budget, we budgeted about 7,000 additional FTEs. And if those FTEs are not filled, those dollars go back to providing care through the discretionary funding. So, if our veterans have to go into the community, then those dollars go back in terms of ensuring that our veterans are getting care either inside the VA or outside the VA.

Mr. WENSTRUP. So it goes back into caregiving specifically?

Dr. ALAIGH. Yes.

Mr. WENSTRUP. Thank you.

Ms. Ilem, Mr. Blake, Mr. Fuentes, Mr. Shuman, I understand your expressed opposition to the proposals in the budget request to enact changes, especially rounding down the cost-of-living adjustment, COLA, to the nearest dollar, which, of course, at most would cost a veteran \$12. I understand the principle of the whole thing. I get that.

But at the same time, when I am in my district, and I am talking to veterans, and I ask them, and they are concerned about certain programs, certain benefits that we have been talking about and they would love to see enacted, I ask them, I said, "Would you be willing to round down," and explained to them what that means, every one of them said yes. You know, they get it in principle. But you know what? Veterans do that for veterans.

So I am a little confused on that one, because it is not what I am getting from the individual veterans, but we always get it from the VSOs. And it has been done in the past.

And, you know, some of those very veterans may benefit from the program that at most would cost them \$12 a year and at least 12 cents a year. That is pretty good insurance policy for some of these types of benefits that they can receive.

So I am feeling a little bit differently on that particular topic when I am out talking to veterans. And I think that that needs to be considered.

We heard a lot of things you are concerned about, and I appreciate you bringing those up. And how do we go about funding and where do the moneys go, that is a big discussion to have. But I really didn't hear many solutions, and I would really like to hear some viable solutions, some actual, realistic solutions you have as to how we can increase our funding and find pay-fors or get offsets within. So I would like to ask each one of you, if you can comment quickly—if you can discuss these with us.

We can go down and start with Ms. Ilem.

Ms. ILEM. I don't have any specific offsets that we can share. I think one of the things, based on our resolutions that we receive from our membership was really put forth what we do legislatively, you know, talks about specific issues of offsetting veterans—you know, one benefit to a veteran to, you know, pay for another pro-



gram. And I think the concern is, you know, throughout our organization, that we want to make sure that programs for disabled veterans are provided to them based on their military service, and we don't want to see an interference or trying to take away another benefit from another group of veterans.

Mr. WENSTRUP. Mr. Blake?

Mr. BLAKE. Mr. Chairman, I think the question somewhat presupposes that in order to get to an increased level of funding you would have to offset or find a pay-for or something like that. I think the first thing we need to do is be honest with exactly how much it is going to cost to provide services, because I think we are—I think what we are missing here is, in the early part of the process of budget development, a lot of the cuts and reductions and figuring out ways to tamp down how much we are going to request takes place within the confines of the Office of Management and Budget, and we never get to, what does it actually take?

I mean, the independent budget puts our recommendations forward, and our numbers are basically our belief of what it takes to provide care. I don't sympathize with the position that you are in, that you have to figure out how to get to those numbers. But, truthfully, I see that as a congressional problem, not our problem. Our problem is we tell you this is what we think it takes, and you have to deal with the political consequences of cutting or offsetting.

Mr. WENSTRUP. Yes. And that is the reality.

Mr. BLAKE. Sure.

Mr. WENSTRUP. Okay? So that is the reality we have. And since I have been here for 5 years, there are things that I know we are way overspending, and we have made some changes and working on some of those changes to bring costs down in other areas. And particularly near and dear to my heart is to get more care to the patients and to our veterans in that regard. That should be the highest priority, especially as we are dealing with this today.

But you can't ignore the reality. And so we are asking you for you to help, because you know what? We are all in this together. And that is the point I would like to make. So I am asking—you know, you talk to veterans. You represent veterans that are going through the process, and they do a lot of talking, and it is a good thing they do, but if they can come back with some evidence and say, "Hey, you know what I have observed and maybe this is the way we can do it," we will take those solutions. So I understand the complaints and the concerns, but solutions are helpful to us.

Mr. Fuentes.

Mr. FUENTES. Just to add to what you were mentioning, Mr. Chairman. You know, there is fraud, waste, and abuse in the system that must be eliminated. There are inefficiencies that must be corrected. You know, there was just a release—I don't know the number exactly off the top of my head—about \$26 million or so that the Secretary estimates to be able to eliminate in terms of his fraud, waste, and abuse task force. That is certainly the right approach, finding where to do that without hurting veterans.

But, frankly, you know, there are these improvements that are much needed. There is also nothing that says that it has to come from VA's budget, right? You have congressional rules that say that discretionary funding, mandatory funding, needs to be offset,

but that doesn't say that it has to come from this Committee's jurisdiction.

Now, I understand that the complications that come with that. But, also, frankly, and it has been the VFW's position for quite some time, sequestration has a lot to do with why VA is receiving—is not able to ask what they need and why Congress isn't able to give them what they ask for.

And we have said for quite some time, and hopefully you agree we need to end this, you know, setting arbitrary budget caps 10 years ago that are no longer, you know, realistic.

Mr. WENSTRUP. Mr. Shuman.

Mr. SHUMAN. Thank you, Mr. Chairman, for the question. You are absolutely right. We are absolutely in this together.

The first thing I want to sort of point out here is that this country has made a promise to veterans. And my colleagues here are right in that the money does not always have to come from the jurisdiction of this Committee.

During his campaign, the President made a promise that he was going to do the right things for veterans, and we want to hold him to that. So we are standing by willing to work with you and the White House to get the funds necessary to be able to take care of the veterans.

To go back to the first point—and sorry the time is over—our members, thousands of them, have to vote on our resolutions, millions, in order to get where we are. And, currently, our members are telling us that they are not supportive of the COLA round down. So I would love to talk you, to the constituents you have, and I would love to make sure that our members are speaking with your office as well.

Mr. WENSTRUP. I am telling you that anecdotally. It is not a scientific study, and it is a not a poll or anything like that, but I just ask the question. I appreciate the input.

And you might understand that it is difficult for any one committee to tell another committee of jurisdiction that they have to start giving up things. So I think you appreciate that.

Mr. SHUMAN. We will tell them for you, Mr. Chairman.

Mr. WENSTRUP. Ms. Brownley, you are now recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman.

I think Mr. Blake pretty much laid it out in his testimony about where the challenges are here in terms of ensuring that we maintain and improve upon the programs we have promised to our veterans and to be able to fund all of the programs.

And with regards to some of these offsets and we—Ms. Alaigh talked about the IU benefit as one example. And, certainly, the Secretary did, in his testimony, kind of back off of that as a way in which to help finance the Choice Program.

But in your testimony, you still state that it is potentially still on the table as an offset. So I just wanted to clear that up. If we can clear that up today, or I am wondering if you have a different perspective.

Dr. ALAIGH. Thank you, Congresswoman. As the Secretary has said, he would never do anything that puts our vulnerable veterans in a compromising position, and so he has committed to looking for

another solution besides the IU at this point and working with all of you on that.

Ms. BROWNLEY. And so are—is that something that you and your staff and Secretary are all are working on?

Dr. ALAIGH. Yes, we are all going to work together on it.

Ms. BROWNLEY. And do you have some sense of when—you know, when you will be able to share that with the Committee so we actually know kind of what we are really dealing with here? Because, right now, it just seems like we are going to figure it out. But—I think this is the time when we are supposed to be really reviewing and digesting a budget so that we can respond to it. So it is difficult when we do not know.

Dr. ALAIGH. Absolutely. We will share it with you as soon as we are ready to share what our alternatives are.

Ms. BROWNLEY. Okay. And the same for the Staab ruling and the emergency care nonservice-connected conditions. There is another, you know, sort of a blank there for how we are going to backfill a \$1.5 billion without taking away items like the Choice Act. So I hear you are going to be working on it, and I think—you know, I am not sure when we will—but it seems like we will have to reconvene another hearing similar to this one to get some of those responses back, Mr. Chairman.

And, you know, the transferring authority, too, is that still something that you believe is on the table to solve all or part of this problem? And if you could talk a little bit about that.

Dr. ALAIGH. Thank you, Ranking Member. At this point, there are three options that we are exploring. The first option is something that we have already done, which is ensure that the Choice Fund continues until the end of this fiscal year. And to do that, what we have done is made sure that the accounts, the Choice accounts, are being used for the 30-day/ 40-mile rule, and then for everything else that our veterans need outside of the VA, we are using the community care funds for that.

That will take us—and we are managing that on a daily basis. That should take us along with the community care funds to the end of the fiscal year. However, it will be at the expense of Choice being trimmed down significantly.

The other options are the transfer authority or infusing new funds into the mandatory funding stream in order to make sure Choice continues at the same pace.

Ms. BROWNLEY. Okay. Seems like we still have a lot of work cut out in order to figure out how we are going to, truly support these very, very important programs for veterans.

On the IVF and adoption regulation that has gone through, I know that we have—the rulemaking has been done, the IVF, and that program is, I think, under way as we speak. And that is good news. I still do not believe we have a rule, regulations for the adoption piece of that.

So I was wondering how we are progressing on that.

Dr. ALAIGH. So the IVF program, you are absolutely right. We have about 37 families who have already contacted us to be part of that program, and we are supportive of continuing the program to the next year. I will get back to you on the adoption rules and where they are at this point, but we are definitely—I mean, that

is part of supporting the whole women's health and overall programs.

Ms. BROWNLEY. Thank you very much.

My time is up. I yield back.

Mr. WENSTRUP. Mr. Bilirakis, you are now recognized for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I thank the panel for their testimony today.

And I thank our veterans for their service.

Dr. Alaigh, I am hearing an uptick in the complaints and concerns about community providers about the VA's ability to comply with the VA prompt pay rules. Particularly providing the expected community care funding shortfall announced just last week, how does this budget support improvements to VA's claims process system, and what, if any, changes are needed in order for VA to fully comply with the prompt payment rule? And then can you say anything to assure providers and encourage them to keep accepting VA patients?

I will tell you that the providers I speak to, the physicians I speak to, want to see veterans. They feel like it is their duty and obligation to see veterans in the community. But they are having a hard time getting paid. And you probably hear it. I think, probably some of my colleagues do too. How could we solve this quickly, because it is a great alternative to the VA, not to—you know, I love the VA. I think that the care is very good in most cases, but as an alternative, some of our veterans want to see private physicians. So please answer that question for me. I appreciate it.

Dr. ALAIGH. Thank you, Congressman. I have to tell you, as a physician, it is just an honor to serve veterans, and there isn't a single physician who—who doesn't get touched by serving a veteran and taking care of a veteran. And I hear the same complaints that you do in terms of prompt payment but also of your process where there is a lot of administrative hassle. And so what we have done is simplified the process at least for the time being where we are requiring less of administrative back and forth and paperwork that they have to submit to streamline the process.

We still have 20 percent of clean claims that are not paid within 30 days, and that is a problem. And so we are working with our TPAs. Our payment to the TPA is within 30 days. The TPAs then have to pay their provider. And so this is one of the areas of focus. The TPAs are willing to work with us, and we are looking at ensuring streamlining and automating of processes to ensure that our providers are getting paid.

In the new RFP that is out, we are going to have much more rigorous and stringent rules and expectations on the prompt pay piece of it. Whatever we are hearing about issues are things that we are incorporating into our new RFP process that is going to be awarded the first part of the next fiscal year.

Mr. BILIRAKIS. How are you utilizing the Federal qualified community health centers? Is there a path there? I mean, would they be an alternative? I know you are utilizing them to a certain extent. If you can elaborate on that, I appreciate it.

Dr. ALAIGH. Yes. They play a critical role in terms of access, especially in those critical access areas where we need to meet the

needs of our veterans. So we are in discussions. We have an MOA with HRSA to ensure that the FQHCs are part of our network as we send our veterans out into the community.

Mr. BILIRAKIS. Okay. Next question: In your budget, what steps have you taken to ensure that complementary and alternative therapy services are available to our veterans? That is very important, and I know that the Committee really cares about that. I sponsored the COVER Act, it passed last year. I want to know the status, the President is going to nominate two veterans, hopefully, two veterans on the Committee soon. You know, based on the budget, in the budget, tell me how we are utilizing—has it increased? Do you plan an increase so that veterans have access to complementary and alternative therapies that are, obviously, certified, but I know they work, and I think the veterans should have the choice to seek what type of therapy works for him or her.

Can you give me an update on that, please?

Dr. ALAIGH. Yes, sir. The complementary and critical medicine is a core piece of how we provide whole health for our veterans, and what we have is 18 flagship sites that are going to be launched in October of this year, one in each VISN, that actually delivers a whole health model. And in that whole health model, you have three prongs. One is to make sure that our veterans are empowered and they come up with their own life plan. The second piece is to equip them, and equip them means to have access to complementary and integrated medicine. And the third piece is treating them. But complementary and integrated medicine is an important part of taking care of our veterans who are dealing with severe pain conditions and opioid addiction and some of the other very difficult-to-treat conditions.

Mr. BILIRAKIS. Thank you. So, if you can give me an update, follow up on this with regard to the COVER Act. I know that the Secretary—I have talked to the Secretary, and he just submitted names to the President. I wanted to see where we are on that. If you could get back to my office, I would really appreciate it very much.

Dr. ALAIGH. Yes, I will.

Mr. BILIRAKIS. Thank you.

And I yield back, Mr. Chairman.

Mr. WENSTRUP. Mr. Takano, you are now recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Blake, how important is it to VSOs or to your VA—how high a priority is it that the 38,000 unfilled positions at the VHA get filled?

Mr. BLAKE. I would say it is critically important, even from the—taking it down to the more narrowly focused SCI level, we have been working closely with the VA to fill approximately 1,000 nurse staffing positions alone in the SCI system of care. It ranges somewhere between 900 and 1,100, but that is just a small snapshot. And that is just in the SCI service alone. If you take that out to a much wider net, I am sure that it is critical to ensuring the VA can function at its maximum capacity.

Mr. TAKANO. Mr. Fuentes, how high a priority is it for you, for your position?

Mr. FUENTES. In the past 3 years in serving our members on VA health care six times and every single time we ask them, how would you improve the VA health care system, the number one answer is hire more doctors. So it is very important to our members. That is what they want to see.

Mr. TAKANO. Mr. Shuman?

Mr. SHUMAN. Thank you, sir. It is absolutely critical. I mean, staffing bleeds into every single—beyond VHA, every single element of the VA, so it is absolutely critical.

Mr. TAKANO. I passed you last time. I am sorry. My eyes are—  
Ms.—

Ms. ILEM. Ilem.

Mr. TAKANO [continued]. Ms. Ilem. Sorry.

Ms. ILEM. Thank you. Yes, absolutely critical to DAV members as well. Hiring at the VA health care system and having access to those providers, you know, plays into having timely access to care.

Mr. TAKANO. So, Dr. Alaigh, did I hear you correctly answer the Chairman that all of the 38,000 positions that are unfilled are funded?

Dr. ALAIGH. So, Congressman, we have a steady state of attrition and hiring, and that steady state for an organization—

Mr. TAKANO. I don't have much time. Can you just answer the question? Are they funded?

Dr. ALAIGH [continued]. There are 7,000 positions that are funded.

Mr. TAKANO. So 7,000 of the 38—so not all of the 38,000 are funded?

Dr. ALAIGH. There is a 30,000 steady state of positions, positions that come and go at any given different time. So our steady state is 30,000.

Mr. TAKANO. I am confused by your answer, because I am hearing 38—the Chairman himself used a figure of 38,000 unfilled positions, and you answered affirmatively that they were funded.

Dr. ALAIGH. We have funded for 37,000 positions, 30 being the steady state and 7,000—

Mr. TAKANO. Okay. So 37,000 are funded. Okay.

Dr. ALAIGH [continued]. Yes.

Mr. TAKANO. So out of the 37. That is quite—that is quite a lot of money that is not being spent. You said that money does get spent, though. It gets spent on community care. Is that what I hear you are saying?

Dr. ALAIGH. We can hire. But it is the goal to make sure that our veterans are receiving care.

Mr. TAKANO. How big of a commitment is it for—how high a priority is it for the VA to fill those positions?

Dr. ALAIGH. This is a very big priority, one of our top priorities for the VA.

Mr. TAKANO. It seems to be a persistent issue, though. Every year, we see the positions unfilled. I kind of see that you are trying to fill up community care funding, that there is this perverse incentive for the VA to not fill those positions and use those savings to fund community care. Have you—there is lot of money being spent on community care. Do they all spend money?

Dr. ALAIGH. No. The money is being spent to hire our staff, our employees, and if the—all the money is not spent, it goes into direct patient care services.

Mr. TAKANO. Well, does that—has all that money been spent? Has all the money been spent?

Dr. ALAIGH. I will have Mark—

Mr. TAKANO. I realize it gets spent on patient care, but it gets spent, looks like, on other programs.

Mr. YOW. Yes, sir. I think what Dr. Alaigh was trying to explain: Typically, we have a large number of vacancies that are open with the turnover that we experience. We have more than 300,000 employees across the VA. No position gets advertised unless the VA medical center believes they have funds to support it. We have 7,025 FTEs—that is a full-year, full-salary, full-time equivalent position—funded in this budget for growth to—with that steady turnover. So, if you are looking at some number above 30,000 vacancies, remember, a lot of that is turnover. It doesn't mean there is extra money sitting anywhere that would be used otherwise.

We have talked about the fact that creation of the medical community care account has eliminated the opportunity at the medical center level to move money from in-house care inside the VA medical center to community care and back when those positions are vacant.

If you are missing a surgeon for some period of time, you will have to send that care out in order to continue to provide care to veterans. If we are able to hire that surgeon back, you would like to be able to bring those moneys back from community care and put it into our direct care system. So that is what she is trying to describe.

Mr. TAKANO. All right. I am still—I feel like I need to spend—my time is out, but I would like to understand more about how this works, because I am very frustrated, and I think the VSO is very frustrated that we have all those positions vacant. I am trying to understand what—it is more than just the money issue. But I don't want to be—I want to be courteous to the Committee.

Dr. ALAIGH. I think just the one thing that we have lost as a result of this is our three Rs—so recruitment, retention, relocation—incentives to make this competitive with the community and the marketplace. You know, we have lost, and that has made it a little more challenging to bring in employees into the system.

Mr. TAKANO. Well, thank you, Dr. Alaigh.

Mr. WENSTRUP. Mrs. Radewagen, you are now recognized for 5 minutes.

Mrs. RADEWAGEN. Thank you, Chairman Wenstrup and Ranking Member Brownley, for holding this hearing today.

Thank you, Under Secretary Alaigh and the VSO representatives on the panel, for taking the time to testify, and we appreciate you being here.

As you know, this budget request calls for increases to veteran services across the board. And in that regard, I would like to praise the Department for their commitment to caring for our Nation's heroes. I hope to continue to work with VA to bring further improvements to veterans' health care and accessibility services, especially

for veterans out in rural and remote areas like my own home district, American Samoa.

However, as is usually the case, there is still much work to be done. For example, I would like the VA to work in conjunction with DOT and other related departments to make improvements to LBJ hospital, the only hospital in the territory, which currently cannot treat our veterans due to lack of adequate resources.

As it stands, our veterans must be flown to Hawaii and put up in a hotel for several days on the taxpayers' dime to receive even the most basic care. Last year alone, \$3.2 million was spent on that exercise alone. That is a lot of money.

This budget is a good first step, I think, and I look forward to more improvements to veteran services to come, especially for our veterans in the remote U.S. territories.

Mrs. RADEWAGEN. My question for you, Dr. Alaigh. The budget cites that the Supportive Services for Veteran Families Program has a presence in all 50 States, including Puerto Rico, the District of Columbia, Guam, and the Virgin Islands, but does not include American Samoa. Does this mean that SSVF services are unavailable in my territory?

And to follow up, how do the needs of homeless veterans and their families vary by geographic region? Specifically, how does the VA work to address the needs of homeless veterans in rural communities that may be particularly isolated from services?

Dr. ALAIGH. Thank you, Congresswoman.

We are committed to serving veterans regardless of where they are. And so if this is a specific issue in the Samoa Islands, we really do want to look into it further.

Since we contacted your office, we are already starting to work with the local hospital there, which is a government hospital. We are looking for ways to collaborate with them, because we are two governmental agencies, and we are going to continue making sure that we synergize our efforts. And if there are still gaps in services, then we will work together on those.

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

Mr. WENSTRUP. Thank you.

Ms. KUSTER, you are now recognized.

Ms. KUSTER. Thank you, Mr. Chairman.

And thank you to the Committee, to the panel, for being with us today. We appreciate it.

I wanted to ask about the issue about consolidated community care network that was outlined in the VA report, this was late 2015, and get back to the question that Mr. Bilirakis had started about the Federally Qualified Health Centers.

My question is, has the VA developed this plan any further to integrate these facilities, especially with regard to this moving to an off-the-shelf health record? And is that a barrier or will that be helpful to integrate the Federally Qualified Health Centers?

Dr. ALAIGH. Thank you, Congresswoman.

Our goal is that veterans get seamless care regardless of where they are getting care. Going down the path of adopting the DoD EHR platform is only our first step. And it is very clear as we are moving down this path that the interoperability and the seamless-



ness of connectivity has to happen with all of our community providers, like FQHCs, and our private physicians at the same time.

Ms. KUSTER. Okay. And then continuing that train of thought about the adequate funding, whether there is sufficient funding to successfully implement the evolution of the electronic health record, how much money will the VA require in the fiscal year 2018 budget to implement the evolution? Because I recall Mr. Shulkin saying the moneys are not included in this budget request.

Dr. ALAIGH. Yes, that is an important question to ask, because this is a huge implementation that is going to take years. But the most important thing, and having learned from the DoD experience, the first 2 years is really about change management, going through the specifications and making sure the standards align.

And so for the first 2 years we have enough in the budget to be able to support the field assessments, going through the specifications, and doing change management. It is going to be in year 3 that we are going to be asking for additional and significantly additional funding to be able to implement it.

Ms. KUSTER. So we shouldn't expect a supplemental budget request for fiscal year 2018?

Dr. ALAIGH. No.

Ms. KUSTER. You are saying it would be 2020.

Dr. ALAIGH. It won't be in 2018.

Ms. KUSTER. Okay. Okay.

The other reason that I am concerned about the requested funding for the IT system, it seems too low to accommodate simultaneous transformations of the electronic health record as well as financial management system, antiquated benefits management system, and one that I continue to try to pursue is a more efficient and effective scheduling system.

So regarding the scheduling, will VA continue to pursue the MASS scheduling pilot, and if not, what does the VA plan to do to improve its scheduling software?

Dr. ALAIGH. Again, a very important point. You know, one of the things that has been responsible for some of our access issues, including discrepancies in wait times, is our complex scheduling system. So we are rolling out the VSE, which is an interim solution, while we are still doing the MASS pilot, because all we are doing right now is contractual negotiations with the DoD product.

So in the meantime, we still are moving ahead with rolling out VSE, which is going to be our interim bridge, and then also seeing what the MASS pilot demonstrates, because we will have lots of learnings just doing that pilot. And we still want to have options of the best software modules to be able to deliver the best care for our veterans.

Ms. KUSTER. Well, many of the Members of this Committee were on the Committee when the Phoenix scandal was all over the news, and we certainly want you to resolve the scheduling issues, use the resources and the personnel that we have efficiently, and not end up back here *daja vu* all over again. So I will wish you well with that.

One last, very quick question. I just have 30 seconds. I am concerned that the VA is not requesting adequate funding for medical research programs, and in particular the research around pain

management and use of opioids to bring down the use of opioids in the system so that we don't continue to create more and more and more people with substance use disorder, veterans that are addicted to opioids, heroin, now fentanyl.

Is there anything that you could say to comment on that?

Dr. ALAIGH. A third of our research funds do go into mental health and substance abuse, including PTSD, suicide, depression. We are going to continue down that route. We will have to look for additional partnerships and other sources of funding, because we are a leader in research. We come up with breakthrough research. The rest of the country follows us. And so we are going to continue that momentum, you know, in that current environment.

Ms. KUSTER. Thank you very much. I yield back.

Mr. WENSTRUP. Dr. Dunn, you are now recognized.

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

Dr. Alaigh, what will be the impact on veterans care if Congress does not act to replenish the Choice Fund, and when will those consequences be felt?

Dr. ALAIGH. This is a serious concern. And we have a plan that we have implemented right now, because under no situation can our veterans ever not have access to high-quality care.

So what we are doing right now is managing the two accounts, the Choice account and the Community Care account, and making sure that both those accounts last until the end of this fiscal year.

There will be unintended consequences if we continue down this path because the Choice accounts will start to be used very judiciously. And so I do know that the TPAs have put in a lot in terms—

Mr. DUNN. Let me interrupt you, if I can right there. The TPAs, you made mention of those earlier, and it sounded like you were saying they were the problem paying on time. I was surprised that you farmed out the third party—the administration of the Choice funds to some external consultant.

Dr. ALAIGH. So this was a program that was stood up in 3 months. And if you look at any other managed care organization, it takes decades to stand up a program like this. And so we are still dealing with bumps along the way, and this is one of the things that we are going to have to work on.

Mr. DUNN. Are there other, less mission-critical areas that you could tap the money from in the VA for the Choice Program?

Dr. ALAIGH. We cannot transfer funds from the discretionary accounts into the mandatory accounts. So we cannot transfer funds—

Mr. DUNN. So maybe from the mandatory—other places mandatory cannot.

Let me change tacks here just for a minute. The vision statement attached to the budget said that the VA will focus on its foundational services, the ones that they can excel in. What are those foundational services?

Dr. ALAIGH. So right now we know the foundational services are primary care, mental health, SCI, polytrauma, prosthetics, mental health. All those are our foundational services, but depending on the marketplace, we will add additional foundational services, for example, high-volume medical specialties, some surgical specialties.

Mr. DUNN. So let me take a dive at the surgical specialties really quickly, one that is near and dear to my heart as I was a former transplant surgeon.

It is my understanding that the veterans who often need transplant care have to travel hundreds or thousands of miles to receive their transplant care, and then it may not even be done at the VA transplant center. It might be in an academic affiliate.

Why is the VA hesitant to let veterans pursue transplants in the transplant centers, certified transplant centers, near their home where we know the transplants are more successful and they are much more likely to get the transplant?

Dr. ALAIGH. Yeah, you are absolutely right, Congressman Dunn. This is an area that we have to redesign and change, because as long as the transplant centers have the best possible outcome after the surgery and have the team that can best manage it, we should be opening up the networks, and we are already doing that in certain cases.

Mr. DUNN. So I can interpret that as that policy is going to go away. We are now going to be able to use the transplant—my veterans in Florida are going to be able to use the transplant centers in Florida and they will not have to go to Pittsburgh or—

Dr. ALAIGH. We are doing a market analysis, and we are going to finish that market analysis in a year, and after that we will show you. But in the meantime, case by case, we are making exceptions and making sure that our veterans are going to the best possible places.

Mr. DUNN. All right. In the little time left let's take a look at the \$226 million line item for modernization and interoperability of the VistA health record system, which I gather we are abandoning, right? We are walking away from that, going onto the DoD system. \$226 million for a system we are leaving? Help me.

Dr. ALAIGH. This includes the change management that we are going to be doing as we are rolling out the new EMR.

Mr. DUNN. You are saying that is the cost of adoption upfront?

Dr. ALAIGH. Yes.

Mr. DUNN. \$226 million?

Dr. ALAIGH. And also maintaining our legacy VistA systems along the way.

Mr. DUNN. Thank you.

I yield back, Mr. Chairman.

Mr. WENSTRUP. Mr. Higgins, you are now recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

Dr. Alaigh, thank you for your service.

I would like to follow up on what my colleague asked. Why does it take a year to figure out what everyone in this room knows is already an accurate conclusion? A veteran should be able to get a transplant in his own home State. This is just common sense.

This is the type of thing that we are tired of. This is the kind of thing that veterans from sea to shining sea come to a veteran like me, as a Representative, and they say, "Captain, why don't they get it in D.C.?"

So please tell us, why does it take a year to figure out what this distinguished surgeon has come to the conclusion of already and, I imagine, the other doctors on this Subcommittee? Why a year?

Dr. ALAIGH. Again, a very valid concern. As you know, the VA delivers some of the best outcomes in quality care, and in order to ensure that our veterans are getting the highest quality of care, we are going to be doing an analysis of all the services that should be provided inside the VA versus—

Mr. HIGGINS. And what does that cost? Because we have just arrived at that conclusion, it costs nothing.

Dr. ALAIGH. And, Congressman, it is not just for transplant services that we are looking at. We are looking at hundreds of different types of specialties and services, and at the same time looking at veteran demand. We are looking at reliance. We are looking at what the highest performing providers are in the network.

Depending on where our veterans get care is directly correlated with the outcomes for our veterans. And we want to make sure our veterans are getting the best possible care.

Mr. HIGGINS. Thank you for your patient response, ma'am. Please understand my passion is strictly reflective of my love for our veterans.

Dr. ALAIGH. We are on the same side.

Mr. HIGGINS. All of us, in one way or another, continue to serve our country. I thank the veteran service organizations present. You have been very helpful to my office. In particular, Matthew Shuman, the director, has been very interactive with my office in helping us as we move forward.

In talking about the budget, as soldiers, sailors, airmen, and marines, we recognize sacrifice for our country. And please let us note that the VA and the VHA has received a significant increase in funding despite the fact that our Nation faces a \$20 trillion debt. That is the people's treasure that we must protect.

And despite that we exist in an era where we face such a danger to the future of our country, the VA and VHA have received a significant increase in budget, which I believe is reflective of the spirit of this Subcommittee and the VA Committee as a whole and of our President and of this body from both sides of the aisle.

So my question, ma'am, if I may jump into veterans homelessness, the VA and many local and State governments have made tremendous strides in reducing the rate of veteran homelessness. However, nearly 40,000 veterans and their families still face homelessness.

The 2018 budget requests 1.7 billion to assist homeless veterans and prevent at-risk veterans from becoming homeless, in part by building a capacity of available residential, rehabilitative, transition, and permanent housing supply. And the VA has a program called a VA Enhanced-Use Lease Program. It occurs to me to be a very wise investment of the people's treasure.

Can you please provide information to the Subcommittee regarding appropriate properties that the VA could utilize for job training, medical services, transitional services, transitional housing for our homeless veterans and their families, please?

Dr. ALAIGH. Yes, we will.

Mr. HIGGINS. And we would like those properties identified. If you could provide that to the Subcommittee, I would appreciate it.

In my remaining 40 seconds, regarding caregivers, under the Program for Comprehensive Assistance for Family Caregivers, 24,555 primary family caregivers were approved in 2016; 33,345 in 2017; and expected 37,100 caregivers for 2018. This is significantly higher numbers than were expected when the program was initially established.

Has the VA begun working to ensure that the Caregivers Program can continue to provide services and stipends to the veterans and caregivers most in need? And can you lay out how the program has and will change to ensure its longevity? This is a crucial program for our veterans.

Dr. ALAIGH. Yes. I mean, the Caregiver Program is a very important fabric of how we keep our veterans at home, independent, and autonomous. So we support the program. We are working on redesigning the program so that we can also offer it to the pre-9/11, the most vulnerable veterans who need it.

But in the meantime, we have a whole compendium of services that we can use to help support our veterans so that they stay at home, our Home-Based Primary Care and Respite Program, lots of different other entities.

Mr. HIGGINS. I applaud your answer, ma'am. And I thank you particularly for mentioning pre-9/11 veterans.

Mr. Chairman, I apologize for going over time. I yield back.

Mr. WENSTRUP. Mr. Chairman, Dr. Roe, you are now recognized.

Mr. ROE. Thank you, Mr. Chairman.

And just an opening round, I know one of the things we hear every year is about how the VSOs are worried about being privatized. And while the Subcommittee was asking questions, I looked up some data. In 2009, the entire VA budget was \$93.7 billion. There were about 240,000 employees, I think, at that time.

This budget request is for \$186 billion. That is for fiscal year 2018. That is in 9 years. That is a doubling in 9 years of the VA budget. And the VA currently has 364,000 employees. It is over 100,000 more people working than 8 years ago or when I came to the U.S. Congress. So I don't see how in the world anybody can make an argument that it has been privatized.

I think what the VA is trying to do is provide the very best care it can for veterans. And if they can't provide it in-house, they wanted a way to provide it outside, just as has been mentioned on the transplants and other things, and I applaud them for that.

And I am sorry that Mr. Higgins just left, but I was in Los Angeles a couple months ago and they are using property there. Ten percent of the homeless veterans in America are in Los Angeles County. And they are using a 387-acre campus, and many buildings that have been abandoned are not used. They are refurbishing those buildings for homeless veterans and creating a village there. And with all the other support services, with the HUD-VASH and so forth, it is a tremendous program.

I was in Fayetteville, Arkansas, Monday, with the Secretary, and they have taken a building on the campus and have rehabbed it for inpatient mental health treatment up to 90 days for alcohol and drug abuse. And we know that Medicare now stops paying after 15

days. You can't do the care in 15 days for drug abuse, and VA has recognized that.

And so they need a shout-out for those programs that they are doing. There are some really good ones around the country. I think we hear all the bad. We don't hear a lot of times the good.

We have a tremendous problem in the Budget Control Act—Mr. Fuentes mentioned this—with budget caps. He is correct. Our discretionary part of the U.S. budget has been almost the same, which means that we have taken away from Education and Department of Defense and other things to provide services for the VA.

And I get a little frustrated sometimes because I know we have done that, and have had other requests that come on from educators, from people in other parts that are very needy parts of our society too.

So I think this Committee has done what it can do in certainly listening to everybody and trying to provide every benefit we can for the VA.

A question that Mr. Takano was talking about that I want to get a little bit clearer myself was that when that money is appropriated and it takes months because of the VA's convoluted way they fill that position, what happens to that money if you hired that physician on day 1, or that nurse, it doesn't matter, that health care provider? That money has been there for 6 months. What happens to that money and where is it? Because it is not spent, because the position isn't filled.

I think that was your question, wasn't it? Yeah.

So—I think I heard Mr. Yow say, and he can, Mr. Yow can answer if he wants to. But if a veteran like myself would come in and need a hernia fixed and there is no surgeon there, would you use that surgeon's salary that you would have been paying to pay for my community care? I think that is what he was asking. Or where is the money? Is it still there?

Mr. YOW. Yes, sir. Remember, what we have in the budget is an FTE, a full-time equivalent salary for 7,000 FTE.

Mr. ROE. That is a person.

Mr. YOW. Over the course of the year—

Mr. ROE. An FTE is a human being, that if you hired him that day would go to work and get a salary.

Mr. YOW. It is a full-year salary for a human being, yes, sir. And when we are hiring new people, those 7,000 FTE may represent 20,000 new hires, depending on when they were hired during the course of the year. So it is new money that goes towards hiring.

In the event that you can't hire someone, say in a remote location, that is what we are talking about, we used to have the ability when it was all within the medical services account to move those funds back and forth between purchasing the care, if we had a vacancy, or if we were able to bring somebody in, bring it back to provide in-house care. It still goes to care for veterans regardless—

Mr. ROE. So it is. We are just not spending it on salary, but it would be spent on paying a physician outside. That is what I am trying to get to. Is that correct?

Mr. YOW. It may well be, or it may be paid—we do something called fee-basis physicians where we hire a contract physician and bring them in-house to provide care.

Mr. ROE. Sure, I mean, but it is paid for care. That money is not just sitting in an account somewhere accumulating?

Mr. YOW. No, sir. It is used. It is all going to care for veterans.

Mr. ROE. Okay. I think that wasn't clear to me either. I agree with that.

I see my time has expired, Mr. Chairman.

Mr. RUTHERFORD. [Presiding.] Thank you, Mr. Chairman. I appreciate that.

I actually have 5 minutes myself now that I have moved into the chair.

Dr. Alaigh, let me ask you this. In your written testimony it says, "In addition to increasing the number of veterans accessing care through the Choice Program, VA is working to increase the number of community providers available through the program."

And I can tell you, as a result of the way some of these providers are being paid, I just passed a letter to Chairman Roe earlier, a provider in Jacksonville, Florida, who is no longer going to see veterans because they are hundreds of thousands of dollars behind in payment. And there is a hospital who has the letter on the way that is also going to no longer see veterans.

And so I am very concerned because one of the purposes for the Choice Program, when Congress enacted that, was because veterans were not receiving access to care that they needed and deserved. And so we now see you are trying to add facilities and we are losing facilities as well. So I am concerned about that. Can you tell me how the VA plans to address this problem?

Dr. ALAIGH. Congressman, this is an important problem and one of the reasons of dissatisfaction in our community providers. And we are working, again, very hard with the TPAs.

But at the same time, all the learnings that we have had from the input that you have been giving us and we have been working together on with our partners here around the table, we are incorporating that into our new RFP process where we will be able to award new TPA agreements where there is more accountability and they are held responsible for prompt payments and making sure that our providers, the providers are satisfied as part of—being part of this network.

Mr. RUTHERFORD. Okay. You know, another concern that I have, when I hear that it is going to take a year to assess transplant facilities that are already certified, and VA is now going to do some, I guess this is like an internal certification that you do of your own? Is that what is going on here?

Dr. ALAIGH. No. This is not a certification process. What we are doing is, as we are looking at how we identify a high-performing network and also identify what services we develop inside the VA based on region and marketplace, we are doing a detailed market analysis.

Mr. RUTHERFORD. If I can interrupt, though, these facilities are already certified. They are out there. Folks are using them every day. And so I am concerned that that is going to take a year.

I am also concerned, I heard you mention that it is going to take 2 years to do an assessment and an alignment to figure out the her and the integration with DoD.

Now, Secretary Shulkin sat at that table and said: We are not in the IT business anymore. We are going to go out and we are going to find product that meets our need. And now I hear you saying that we are going back to the old 2-year process of studying something, looking at something, figuring out what the elements need to be to create this integration.

Tell me what this program needs to look like that is so different that it is going to take 2 years to get alignment.

Dr. ALAIGH. Congressman, any big project like an EMR implementation requires a lot of change management. We have providers, we have nurses, we have clinical teams that have been used to using a certain electronic health record. It is sort of part of the core of how we deliver care today.

In order to make sure that the off-the-shelf product is customized to all the different elements of care that we have incorporated into the VA, because the VA does such amazing things with team-based care and PACT teams, we are going to have to customize a lot of those standards and specifications.

That is what is going to take time. We are going to have the frontline physicians, nurses, all involved with this. There are different, like there is an OR piece. There is a behavioral health piece. All those things are going to happen because it is going to be a bottom-up approach. EMR implementation cannot be a top-down approach. It has to be a bottoms-up approach.

Mr. RUTHERFORD. Seems like you just go pick it off the shelf. I mean, that is what Secretary Shulkin was talking about.

My time is up. Thank you very much.

Mr. Sablan, 5 minutes.

Mr. SABLAN. Thank you. Thank you very much, Mr. Chairman. And I appreciate very much you allowing me to join you this afternoon.

Dr. Alaigh or Mr. Yow, what efforts are being made to recruit and retain—well, let me go back. Let me try to understand, I think, Mr. Takano brought it up, you have 7,000 vacancies or was that 37,000 vacancies?

Dr. ALAIGH. We have the budget to support a 7,000 increase in FTEs.

Mr. SABLAN. FTEs. And that is medical professionals or that includes clerical—

Dr. ALAIGH. It could be everything.

Mr. SABLAN. Everything, okay. And you already have—right now you have over—some 180,000 employees?

Dr. ALAIGH. Over 300,000.

Mr. SABLAN. Okay. Right. Thank you.

So let me go parochial here. What efforts are being made to recruit and retain health care professionals for remote and underserved areas, and have they been successful?

Let me say this. I understand that staff from the Pacific Island Healthcare System, from staff, that a licensed clinical social worker position was approved for my district in Northern Marianas. What is the status of that recruitment?

Dr. ALAIGH. I am sorry, for your social worker?

Mr. SABLAN. Yes.

Dr. ALAIGH. I would have to get back to you on that.



Mr. SABLAN. Okay. And if you do have that information, we have a way of getting out Federal job announcements on a weekly basis. And if you would share with us, then we could help you promote, provide that information in our newsletter. It goes out to, you know—

Dr. ALAIGH. Yes, absolutely. In fact, there are two programs—

Mr. SABLAN [continued].—thousands of people. Because right now you only have a clerk who handles appointments and a fee or a contracted physician. Thank you.

You also mentioned earlier that the VA is trying to manage Choice so that funds last through the end of the fiscal year. Could you explain how the VA will do that? When I thought you mentioned prioritizing those veterans, I thought you also mentioned prioritizing those veterans living 40 miles from the VA facilities. Is that correct?

Dr. ALAIGH. Correct.

Mr. SABLAN. So those veterans who live 40 miles away from a facility will be prioritized or if they travel by sea or by air.

Dr. ALAIGH. Yeah. They will still be prioritized as part of the Choice Program, and then we still have Community Care funds for the other veterans.

Mr. SABLAN. Okay. Right.

So, Mr. Yow, what is the FTE formula for determining the number of health care professionals needed in remote and underserved areas, particularly, again, areas like the Northern Mariana Islands?

Mr. YOW. Yes, sir. I don't believe that VA currently has any sort of a standardized staffing methodology to determine that. It has been determined at a local level based on resource availability.

I believe we are in the process of looking at several different types of models to use. One of which we are looking at is the DoD model for their fixed facility hospitals to see if we might be able to standardize staffing across the VA. But it has been very much a decentralized process.

Mr. SABLAN. But neither VA or DoD has a facility in the Northern Mariana Islands. So how do you use that model to—how do you use it to get information on the number of people you need?

Mr. YOW. Yes, sir. It would be driven by the patient demand that you would have in that area and the scale of the size of the local facility. But like I say, we are very much in the beginning stages of that process.

Mr. SABLAN. And my next question is moot, I guess.

Thank you very much. Thank you. I yield back my time.

Mr. RUTHERFORD. The gentleman yields back. Thank you, Mr. Sablan.

I believe Chairman Roe has a follow-up question.

Mr. ROE. I do, just very briefly. And thank you, Mr. Chairman for yielding.

A follow-up from what Dr. Dunn was talking about just a minute ago. If Congress does not replenish the Choice Fund, will wait times lengthen like they were before Phoenix?

Dr. ALAIGH. Yes.

Mr. ROE. Okay. That is one thing I wanted to know.

Will veterans be able to seek appointments in the community like they have before if the Choice is not replenished?

Dr. ALAIGH. No.

Mr. ROE. And will the TPAs have to let staff across the country go if it is not replenished?

Dr. ALAIGH. Yes.

Mr. ROE. They will, okay.

Those were the three things I would have liked to have placed on the record. And I yield back.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

I believe Mr. Takano has a follow-up as well. Oh, I am sorry, Ms. Brownley.

Ms. BROWNLEY. No, that is fine. Go ahead.

Mr. TAKANO. So I just want to get clear about, Dr. Alaigh—or is it Dr. Young is next door? Mr. Yow, okay. I just can't read the names. My eyes can't see. These are reading glasses. These are not binoculars.

So let me get this straight. So you have 7,000 funded FTEs for personnel in VHA, but how many vacancies are there?

Mr. YOW. I have heard the Secretary use numbers between 35,000 and 45,000, but I think our personnel staff are trying to go back and verify those. We have a number that are open for any period of time for repeated vacancies for things like nurses and so forth. So I believe they are trying to go through right now and scrub that and come back with a better estimate.

But like I say, typically we have about 10 percent of our total workforce that will turn over within a year, so that would be about 30,000 at any given time that we would be recruiting.

Mr. TAKANO. So there is a 10 percent turnover, but there are also positions that are unfilled in addition, right?

Mr. YOW. Yes, sir.

Mr. TAKANO. So the total workforce represents a shortfall in what is needed, and so I am trying to get a sense of that.

Mr. Fuentes, you mentioned earlier, I want you to kind of explain more what you meant about that you feel that the VA's budget was shorted or constrained by sequester. Can you elaborate just a little further on that?

Mr. FUENTES. Yes. Thank you, Congressman.

So sequestration occurred because, you know, this was a super committee that was created in 2010, so essentially reduced the budget over 10 years for a certain amount of—I forgot the exact billions amount of money. They failed, so then it was an arbitrary every year 10 percent cut of the budget.

There were negotiations the past 4 years. In 2018 the fiscal—the budget for fiscal year 2018 reverts back to those budget caps that were set 7 years ago. So what really happens is when you have, you know, the overall cap, then you have to decide how you are going to split that money.

And really, because of that, VA is impacted in how much they can request because OMB tells them you need this much money but this is only how much you can get. And then it also limits Congress' ability to fully fund what VA has requested because of the needs of other departments, other committees, and other programs.

Mr. TAKANO. Well, thank you.

And I just have one more—

Mr. ROE. Would the gentleman yield?

Mr. TAKANO [continued]. I do want to ask one more question, if I can just ask the last question. But I will yield.

Mr. ROE. Just very briefly, just to put that in context. Like I said a moment ago, I was here for the BCA. We had a number in the discretionary part of the budget that we funded. We have taken money away from other departments and almost doubled, as a matter of fact over doubled the VA's budget, just for clarification. I yield back.

Mr. TAKANO. Thank you, Mr. Chairman.

If I could, I just want to ask a question on homelessness. It was mentioned before.

In 2015, the Supportive Services for Veteran Families, SSVF programs, received a nationwide surge in funding. That surge consisted of about \$300 million to 56 communities, including my own, over 3 years. Those funds dry up at the end of this fiscal year.

In order to maintain the same levels of services and prevent the expiration of these surge grants, the SSVF program would need up to \$80 million more in fiscal year 2018 than the Department requested.

Now, many communities that receive that money say it is still necessary to end veterans' homelessness in their areas, and some communities have reached the goal of ending veterans' homelessness with that money, say that it is also necessary to rapidly rehouse newly homeless veterans in their areas. These areas will need funding for the SSVF program.

Now, please explain why the Department's budget did not reflect the cost of maintaining these surge grants.

Dr. ALAIGH. I can tell you that homelessness is one of our most important priorities. We have made huge strides in fighting homelessness. We have a 4 percent increase in our homelessness budget for fiscal year 2018.

And we will continue to make sure that we are working on appropriate case management programs, appropriate housing programs, and also the grant programs that all of your communities get in terms of the ability to fight it. About 50 percent of our funding actually goes to those grant programs in each of your communities.

Mr. TAKANO. I am going to take this to follow up for the record, in written, but as I understand it, HUD has cut from \$60 million to \$7 million funding for the HUD portion. I would like to be able to—if you—if the VA considered that as they are making their requests. But I will take that for the record later.

Dr. ALAIGH. Thank you.

Mr. RUTHERFORD. Thank you. The gentleman's time has expired. Ranking Member Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Since we have been talking so much about the vacancies within the VA, which is a very, very important topic, I just wanted to ask a question, because I know that we have had many hearings about HR services and the vacancies that needed to be if I would within HR.

Can you tell me, within HR across the board in the VA, how many vacancies there are within Human Resources? These are the people that actually hire the people.

Dr. ALAIGH. Ranking Member, this is one of the weak links for us right now, and we don't have enough HR staff to support the hiring process. And we are looking at different ways of improving that hiring process.

One of those programs that I know I was talking to Chairman Wenstrup about is the WARTAC program where servicemembers in the last 6 months before separation can be trained while they are still in their military facilities and be brought into the VA system.

And so that is one of the things that we are going to be focusing on as we are trying to hire HR staff, scheduling staff, and logistics staff. Those are going to be our three focus areas.

Ms. BROWNLEY. Just it is hard for me to imagine that an HR staff—I mean, I can understand doctors. I can understand nurses. I can understand a lot of reasons and barriers for filling those pipelines and hiring those people. It is hard for me to understand that we can't fill positions in Human Resources. It is just hard for me to understand. And I would like to know a little bit more about that, and I would like to know with accuracy what are the vacancies within Human Resources.

My colleague here is also saying that I know we had a hiring freeze. I don't know if that freeze is still on or off.

Mr. TAKANO. Does it affect HR in particular?

Ms. BROWNLEY. There is a freeze on human resources?

Dr. ALAIGH. No, there is no freeze on any of the field positions at all. The field can hire, including HR, IT staff, and all the staff.

Ms. BROWNLEY. Okay. And then the last thing that I just wanted to get back to for a minute, which we talked a little bit about in my office yesterday, is Cerner and the electronic health records.

So I was wondering if you could give the Committee a basic timeline. I think Mr. Rutherford is surprised that he is hearing that it is going to take kind of 2 years to gear up with the Cerner system to have compatibility with the DoD.

And you have given all the reasons why that is. And I think I understand it a little bit more because we had deeper conversation in my office yesterday. But, you know, as I said to you in my office, I am like, I am surprised, because I was as surprised like you were. But if you could provide us—or if you could tell us right now, which would be great—what you believe the timeline is.

I know you said in the office it is going to take 6 or 8 months to negotiate a contract, and then it is going to be kind of a 2-year period to get up and going, and that is the interoperability between the VA and the DoD. And then we have got to figure out—the Cerner system doesn't come with automatic interoperability with community partners.

Dr. ALAIGH. Right.

Ms. BROWNLEY. And so that all has to be figured out too.

So I started to think yesterday, well, this is going to be a pretty extensive timeline before we actually get to the place that we all want to be. So do you have a specific timeline that you could share with us so that we can monitor it?

Dr. ALAIGH. Yeah, absolutely. And what we are committed to do is once we have developed the high-level implementation plan we will share it with you. You know, you have been, the Committee has been amazing when it comes to every step of the way, as we have developed new programs, including the new care programs.

So we will be sharing this with you along the way, but, yes, 3 to 6 months for negotiation and executing on the contract and then preparing the field for it. And we are talking—this is what happens in EMR implementation at this scale. This is not different than the VA. The DoD is going through this, and this is one of the largest implementations ever for any health care system.

And you want to do it right. It is patient safety. You don't want to lose data. You want to make sure all the users know exactly what to do and have all the key elements of care that are going to ensure that the patient is getting the best possible care.

So this is not something that you just do with the turn of a switch. This is something that has to be done very carefully. And, again, as I said, it has to be a grassroots effort. It is not something that we just say this is what the product is and you just go ahead and implement it.

But I can understand how you are feeling about this. It is going to be a multiyear, you know, 5- to 10-year project at this point.

Ms. BROWNLEY. Well, what I am interested in, and I hear it and I am understanding it much better, but what I would really like is a very specific timeline in terms of what the implementation looks like.

Dr. ALAIGH. Yeah, and we will share it with you. The Secretary is so committed to making sure that we are walking with you every step of the way. So we will be transparent.

Ms. BROWNLEY. Okay. And I understand that there is, you know, the VA would have to issue a solicitation to Cerner. I am not quite sure I fully understand what all of this means. But if you have to offer a solicitation in the negotiations of the contract, does that make sense to you at all?

My understanding is a solicitation to support the fact that you are awarding the sole source contract. But I guess my question is, have you looked into that, and if you have, are you going to need any kind of legislation to move forward with that?

Dr. ALAIGH. My understanding is no, but if we do, we will get back to you on that.

Ms. BROWNLEY. Okay. Very good. Thank you.

I yield back.

Mr. RUTHERFORD. The gentlelady yields back.

Before we close, I would like to have a follow-up myself with Mr. Yow.

I presume that hospitals run a lot like other facilities that require fixed-post positions. I want to go back to this vacancy situation a moment. Fixed-post positions often require overtime. Do you have an overtime budget at VA?

Mr. Yow. We will have to get that for you. I don't have that with me, but we do track it.

Mr. RUTHERFORD. Okay. And if you could at the same time, what I would like to know is, number one, what is the overtime budget; and number two, how much of that budget overtime is directly re-

lated to the vacancies that you are being forced to carry? Can you get that for me as well?

Mr. YOW. I am not as confident in the second half of your question, to be able to differentiate the vacancies versus the overtime compared to anything else, but we will give it our best effort.

Mr. RUTHERFORD. Okay.

Dr. Alaigh, you don't track it that way?

Dr. ALAIGH. Like I said, we are going to go back and look into it.

Mr. RUTHERFORD. Okay. All right. Thank you very much.

I thank all of you once again. I really appreciate your testimony here today. If there are no further questions, the panel is now excused.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extemporaneous material. Without objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 3:50 p.m., the Subcommittee was adjourned.]

## A P P E N D I X

### Prepared Statement of Joy Ilem

Chairman Wenstrup, Ranking Member Brownley and Members of the Subcommittee:

On behalf of DAV (Disabled American Veterans) and as one of the co-authors of the Independent Budget, along with Paralyzed Veterans of America and Veterans of Foreign Wars of the United States, I am pleased to present our views on the resource needs of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) for fiscal year (FY) 2018 and advance appropriations for FY 2019. I associate my remarks with the statements and recommendations provided by our Independent Budget partners for VHA medical care accounts, construction accounts and the National Cemetery Administration. I will concentrate my remarks on the budgetary needs of a few of VA's most critical programs for ill and injured veterans—mental health care, suicide prevention, homelessness, women veterans and caregivers.

While we appreciate the increases recommended in the President's budget for veterans health care in FY 2018, we are concerned the budget will not meet increasing demand for care and allow VA to meet its goals of providing timely, high quality care to veterans both in VA and the community. We applaud Secretary Shulkin for his leadership and efforts over the past few years to improve veterans' access to care and timeliness of services with a focus on creating a strong management team, increasing operational efficiency, streamlining and replacing outdated business processes, modernizing the veterans benefits system, health infrastructure and information technology (IT) system to include a new scheduling package and electronic health records system. The Secretary has also set a number of priorities to include: greater choice for veterans; building a high performing network of care to enhance VA services while optimizing community care options, expanding mental health services to veterans in crisis with less than honorable discharges, and an increased focus on suicide prevention efforts to eliminate veteran suicide. While we welcome increased funding to improve care and services for ill and injured veterans we want there to be an honest assessment and discussion about what the real costs are for accomplishing all of these important goals.

DAV, along with our Independent Budget partners note two proposals contained in the Administration's budget that we strongly oppose. One, a provision that would scale back VA's Individual Employability (IU) benefit for thousands of veterans that are unable to maintain gainful employment as a result of their service-connected disability. Specifically, this proposal would terminate existing IU ratings for veterans, along with associated ancillary benefits, when they reach the minimum retirement age for Social Security purposes, currently 62, as well as cut off IU benefits for any veteran already in receipt of Social Security retirement benefits. This proposal is simply an unjust penalty and would place an undue financial hardship on all service-disabled veterans in receipt of IU and their families.

The second proposal would round down cost-of-living adjustments (COLAs) for disability compensation, Dependency and Indemnity Compensation (DIC) and some other benefits for the next 10 years. Veterans and their survivors rely on their disability compensation for essential purchases such as food, transportation, rent and utilities. This provision would unfairly target disabled veterans, their dependents and survivors to save the government money and offset the cost of other federal programs. All totaled, VA estimates this proposed COLA round down would cost beneficiaries close to \$2.7 billion over the next 10 years. We are pleased that the Secretary acknowledged the negative impact the IU proposal would have on service-disabled veterans and indicated he was interested in finding another funding source to pay for Choice. We ask the Subcommittee to reject these proposals and reconsider the resources necessary for VA to meet the needs of our nation's veterans.

### Mental Health Care

An independent study found that most of VA's mental health providers were working at peak capacity and despite VA's concerted effort to hire more mental health clinicians, shortages still exist at some locations. Without sufficient resources, the Independent Budget veterans service organizations (IBVSOs) are concerned that this could potentially affect veterans' access to timely and appropriate care, particularly for specialized mental health services.

Demand for VA mental health care services has grown significantly as Vietnam veterans age and our more recent war fighters return from combat deployments (often multiple deployments) and leave military service. Experts estimate that about 20 percent of our newest generation of war veterans are affected by post-traumatic stress disorder (PTSD). Researchers note that veterans using VA care from Operations Iraqi Freedom, Enduring Freedom and New Dawn (OIF/OEF/OND) have a high burden of post-deployment mental health challenges (56 percent have a mental health diagnosis). Subgroups within this population, such as service-connected women veterans, also have an even higher prevalence of mental health needs. While VA has made progress and focused its efforts on outreach, decreasing stigma and improving access to a wide variety of mental health services, there continue to be unmet needs. Many of our most vulnerable veterans have risk factors associated with or exacerbated by their military service that lead to family disintegration, legal issues, unemployment, homelessness and unfortunately, in some cases, suicide.

Despite the challenges, research indicates that veterans who are engaged in VA care and treatment programs are less likely to take their lives. Likewise, veterans with serious mental illnesses using VA health care have longer life expectancies than other Americans with such conditions. Integration of mental health services into VA primary care settings and the development and use of evidence-based practices to treat disorders such as PTSD linked to combat and sexual trauma have proven effective. We are pleased that VA, as part of its suicide prevention efforts, is also beginning to use analytic predictive models (VA REACH VET initiative) to better identify at-risk veterans. While problems, including the timeliness of care and sufficient staffing levels remain at certain locations, we believe veterans with serious mental illness, PTSD (associated with combat or sexual trauma), or post-deployment mental health challenges are best served by VA's highly specialized and comprehensive mental health care model.

VA's primary care teams with integrated behavioral health services routinely identify and refer veterans for advanced screening for such commonly diagnosed conditions as depression, anxiety, and substance use disorders. We commend VA for ensuring mental health is considered an important part of a veteran's overall health-but this new model of care has increased the need for mental health services among thousands of VA patients who have not previously used these services. VA will need to continue to attract, hire and train a sufficient number of mental health professionals, including family and marital counselors and community partners in some locations to meet rising demand and provide timely and individualized care. VA must also continue its efforts to help family members coach struggling veterans into care and keep them engaged in treatment. VA must also focus on meeting the diverse needs of its veteran population to include elderly veterans, Vietnam veterans, and women veterans.

PTSD often co-occurs with other mental health issues including substance use disorders, depression, and traumatic brain injury. Veterans with "dual diagnoses" are often among the most difficult to treat and require intensive care and case-management. VA must continue to research more effective treatments to address these complex patients with comorbid conditions. Likewise, clinicians must have the ability to schedule and carry out more resource intensive, evidence-based treatments for veterans who need it. VA clinicians are beginning to understand the value of peer specialists as these professionals are often able to engage isolated veterans because of their shared military experience, and better assist veterans with patient education and navigating VA's complex health care system.

VA must have sufficient resources to treat case-intensive veterans with serious mental illness, employ more peer specialists, properly staff the veterans crisis line, increase outreach and focus on shared prevention efforts, and develop programs that meet the unique needs of women veterans who are at high risk for homelessness and suicide.

There must be continued oversight by the Subcommittee to ensure that VA has the resources necessary to provide timely and individualized mental health care to a diverse veteran population. Sufficient resources are necessary to meet increased demand for specialized mental health care services for PTSD, substance use disorder, serious mental illness or for veterans who have experienced military sexual



trauma. VA must also have sufficient resources to properly staff the veterans crisis line, improve suicide prevention efforts and develop programs that meet the unique needs of women veterans who are at high risk for homelessness and suicide.

We urge the Subcommittee to ensure VA mental health programs continue to receive adjustments commensurate with increased workloads and continue to monitor VA's ability to fully implement newly authorized services and programs, such as those contained in Public Law 114-2, the Clay Hunt Suicide Prevention for American Veterans (SAV) Act.

Another issue that will require the Subcommittee's oversight is the proposal to provide veterans with other than honorable discharges access to urgent health and mental health services. We commend Secretary Shulkin for taking steps to address the needs of this population (an estimated 500,000 veterans). We know that many of these individuals have PTSD, experienced military sexual trauma or have undiagnosed mental health issues or a mild traumatic brain injury that may have contributed to behavior that led to their less favorably characterized administrative discharges.

While we acknowledge the Secretary's assertion that he does not require increased funding to address the potential increase in workload, we believe the impact on access to mental health care could be significant and may require hiring of additional providers as well as clinical and Vet Center space to accommodate increased demand. We recommend that VA identify the full estimated cost of implementing this decision and request that Congress provide additional funds if necessary. The IBVSOs believe these veterans need and should receive this critical care, especially veterans who may have sustained a brain injury during military service or suffering from a mental health condition that went undiagnosed or untreated.

### **Veterans' Homelessness**

Unemployment, homelessness and suicide are often the consequences of a failed mental health safety net. Since 2010, based on intensely focused resources and efforts, VA and its partner agencies have decreased the numbers of veterans who are homeless by nearly 50 percent.

In the FY 2018 budget plan, the Administration requested less funding for VA's psychiatric rehabilitation and homeless veteran domiciliary beds and a significant cut to funding for these beds in FY 2019. These cuts will undermine veterans' recovery. It is unrealistic to expect veterans who are homeless or in unstable housing to achieve difficult treatment goals such as achieving sobriety (or even reducing dependency upon substances) or attending to basic hygiene, independent living and vocational skills in order to successfully reintegrate into their communities. Psychiatric rehabilitation and domiciliary beds were designed as a less intensive and more cost-effective alternative which still give veterans a stable environment from which to launch recovery. Many of the veterans using such programs also have significant medical and mental health issues to address after living on the street. Without access to stable, supervised lodging and adequate nutrition and rest, these vulnerable veterans' chances to recover from years of addiction and/or significant chronic mental illness including psychoses and severe PTSD are severely jeopardized.

Unfortunately, the progress made through collaborations between VA, other federal agencies, states and community partners appear imperiled by the current budget proposal. Proposed cuts in programs will impact the ability for homeless veterans to receive comprehensive services. While these proposals are outside of the House Veterans' Affairs Committee's jurisdiction in agencies such as HUD, the Interagency Council on Homelessness, the Legal Services Corporation, the Small Business Administration and Medicaid-they will impact this population. VA has invested a significant amount of resources to reduce the number of homeless veterans and we are very concerned the potential cuts to these important programs could undermine VA's progress to end homelessness among this population. VA's ability to work with other federal, state, and local agencies is critical to providing a comprehensive set of services to veterans who are homeless-from rehabilitation to reintegration into society with a goal of good health, recovery from mental illness or addiction and long-term stable employment and housing.

### **Women Veterans**

The delivery of care for women veterans has been a special challenge for VHA. While the number of women serving in the military continues to grow as does the number of women coming to VA for care, women still comprise a relatively small

portion (about 11 percent) of VA's patient population. For these reasons, it has often been difficult for VA, especially outside of urban population centers, to provide high-quality comprehensive services in-house to women. Today, women serving in combat theaters are exposed to serious injury or death like their male counterparts. This new reality requires a focus on meeting the unique needs of an increasing number of women veterans in a health care system historically devoted to the treatment of men.

Learning how to care for wounded women veterans, half of whom are of child-bearing age, and their particular health issues and transition and rehabilitation needs includes learning how to best meet their needs for prosthetic and assistive devices. The IBVSOs recognize and commend the VA's efforts to enhance the care of female veterans in regard to technology, research, training, repair, and replacement of prosthetic appliances through the establishment of a women's prosthetic working group. The working group's mission was to eliminate barriers to prosthetic care experienced by women veterans and change the culture and perception of women veterans through education and information dissemination.

The IBVSOs recommend the Medical Services appropriation for FY 2018 be supplemented with \$110 million designated for women's health care programs. These funds would be used to help the VHA deal with the continuing growth in women veterans coming to VA for care, including coverage for gynecological, prenatal, and obstetrical care, other gender-specific services, and for expansion and repair of facilities to improve privacy and safety for women receiving care. VA must also be able to continue its important research on the health impacts of wartime service on women veterans to better address the high rates of homelessness, suicide and unique transition challenges among this population.

Additional funds would also aid the Department in its efforts to transform the culture of the system to ensure women veterans are provided equal benefits and health care services, have access to comprehensive care in a safe, private and comfortable setting and are recognized for their service and made to feel welcome at VA. Funds are necessary to address identified gaps in current programs and services, particularly post-deployment readjustment services for women veterans.

Like all veterans, women veterans deserve the opportunity to receive care in VA with access to its highly specialized transition and rehabilitation services, veteran-focused research and care and psycho-social wrap-around supportive services. This is especially critical for service-connected women veterans, women veterans with wartime service and veterans who have experienced sexual trauma.

### Caregiver Support

A final issue we ask the Subcommittee to consider championing is fixing the inequity of the current law supporting seriously disabled veterans' caregivers. The IBVSOs have worked diligently for many years as a part of a larger coalition of veterans organizations that promoted the advent of family caregiver support services for severely injured and ill veterans. Congress enacted Public Law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010. However, that law limited services and supports to family caregivers of veterans who were injured or became severely ill in military service only on or after September 11, 2001. That omission left thousands of veterans' families without the level of caregiver support and services they needed because those veterans' health challenges or war injuries occurred before that effective date.

Legislation has been introduced in both Chambers that would address this inequity and improve the lives of tens of thousands of veteran families. Not only is it the right thing to do for seriously ill and injured veterans, it will save the federal government a significant amount of resources that otherwise would need to be spent to provide more costly institutional care solutions for these veterans. We ask that resources be included in the budget to resolve this issue.

In closing, we ask the Subcommittee to consider, as the budget process moves forward, that this is very critical time for VA. The new Administration has pledged support for our nation's veterans and Secretary Shulkin has committed to carry out that promise by creating a system that is worthy of their service and sacrifices. As VA moves forward to rebuild trust with veterans, make needed reforms and carry out modernization plans to strengthen and improve the VA, for the benefit of those who served, it is critical it has the resources and support it needs to be successful.

Mr. Chairman, thank you for the opportunity to share the Independent Budget recommendations at this hearing today. I am prepared to answer any questions you or other members of the Subcommittee may have.

### Prepared Statement of Carl Blake

Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee, as one of the co-authors of The Independent Budget (IB), along with DAV and Veterans of Foreign Wars, Paralyzed Veterans of America (PVA) is pleased to present our views regarding the funding requirements for the delivery of health care for the Department of Veterans Affairs (VA) for FY 2018 and advance appropriations for FY 2019. On the following page, we have included a side-by-side comparison of funding recommendations previously appropriated for FY 2017 recommended by the Administration by the IB for FY 2018, as well as the advance appropriations for FY 2019.

	FY 2017 Appropriation	FY 2018 Advance Approps	FY 2018 Admin Revised	FY 2018 IB	FY 2019 Advance Approps	FY 2019 IB Advance Approps
<b>Veterans Health Administration (VHA)</b>						
Medical Services	45,505,812	44,886,554	45,918,362	64,493,555	49,161,165	69,450,838
Medical Community Care	7,246,181	9,409,118	9,663,118		8,384,704	
<b>Subtotal Medical Services</b>	<b>52,751,993</b>	<b>54,295,672</b>	<b>55,581,480</b>	<b>64,493,555</b>	<b>57,545,869</b>	<b>69,450,838</b>
Medical Support and Compliance	6,524,000	6,654,480	6,938,877	6,657,955	7,239,156	6,793,408
Medical Facilities	5,321,668	5,434,880	6,514,675	5,796,343	5,914,288	6,562,579
<b>Subtotal Medical Care, Discretionary</b>	<b>64,597,661</b>	<b>66,385,032</b>	<b>69,035,032</b>	<b>76,947,853</b>	<b>70,699,313</b>	<b>82,806,825</b>
<i>Medical Care Collections</i>	<i>3,558,307</i>	<i>3,627,255</i>	<i>3,271,000</i>		<i>3,277,000</i>	
<b>Choice Program**</b>	<b>2,900,000</b>		<b>3,500,000</b>		<b>3,500,000</b>	
<b>Total, Medical Care Budget Authority</b>	<b>68,155,968</b>	<b>70,012,287</b>	<b>75,806,032</b>	<b>76,947,853</b>	<b>77,476,313</b>	<b>82,806,825</b>
<i>(including Collections)</i>						
Medical and Prosthetic Research	675,366		640,000	713,200		
<i>Millions Veterans Program</i>				65,000		
<b>Total, Veterans Health Administration</b>	<b>68,831,334</b>	<b>70,012,287</b>	<b>76,446,032</b>	<b>77,726,053</b>		
<b>General Operating Expenses (GOE)</b>						
Veterans Benefits Administration	2,856,160		2,844,000	3,134,540		
General Administration	345,391		346,891	406,454		
Board of Veterans Appeals	156,096		155,596	158,196		
<b>Total, GOE</b>	<b>3,357,647</b>		<b>3,346,487</b>	<b>3,699,190</b>		
<b>Departmental Admin/ Misc. Programs</b>						
Information Technology	4,278,259		4,055,500	4,361,502		
National Cemetery Administration	286,193		306,193	291,085		
Office of Inspector General	160,106		159,606	162,545		
<b>Total, Dept. Admin/ Misc. Programs</b>	<b>4,724,558</b>		<b>4,521,299</b>	<b>4,815,132</b>		
<b>Construction Programs</b>						
Construction, Major	528,110		512,430	1,500,000		
Construction, Minor	372,069		342,570	700,000		
Grants for State Extended Care Facilities	90,000		90,000	300,000		
Grants for State Vets Cemeteries	45,000		45,000	46,000		
<b>Total, Construction Programs</b>	<b>1,035,179</b>		<b>990,000</b>	<b>2,546,000</b>		
Other Discretionary	201,000		180,214	203,000		
<b>Total, Discretionary Budget Authority</b>	<b>78,149,718</b>		<b>85,484,032</b>	<b>88,989,375</b>		
<i>(Including Medical Collections)</i>						

**\*\*Choice Program funding for FY 2018 includes the expected carryover of \$600 million from the previous fiscal year as well as \$2.9 billion in new funding for the program. All Choice program funding is currently scored as a mandatory cost for VA.**

The IB's recommendations include funding for all discretionary programs for FY 2018 as well as advance appropriations recommendations for medical care accounts for FY 2019. The full budget report, released by The Independent Budget in March, addressing all aspects of discretionary funding for the VA can be downloaded at [www.independentbudget.org](http://www.independentbudget.org). The FY 2018 projections are particularly important because previous VA Secretary Robert McDonald admitted last year that the VA's FY 2018 advance appropriation request was not truly sufficient and would need significant additional resources provided this year. We hope that Congress will take this

defined shortfall very seriously and appropriately address this need. Our own FY 2018 estimates affirm this need.

We appreciate the fact that the Administration's recently released budget request for FY 2018 includes some increases in discretionary dollars for the Medical Care accounts above what had been previously provided through advance appropriations. Before addressing our specific budget recommendations, it is important for us to address the notion that VA does not need any additional resources, based on the expansive growth of overall VA expenses in the last 10 years. These ideas are not grounded in thorough analysis of demand and utilization of VA health care. Perhaps Congress can explain how the VA can take on significantly more demand for services both inside VA and in the community, and yet meet that demand and utilization with less resources—an assertion peddled by some organizations. While VA has seen substantial growth in its funding needs over the last decade, much of that is reflected in mandatory benefits to include the implementation of the Post-9/11 GI Bill. The fact is demand for health care services and actual utilization continue to rise at a significant rate. It may be possible to wring some efficiency savings out of VA to free up additional resources to address growing demand, but history has proven that process will not be sufficient to provide all of the resources VA needs to deliver on its promise to the men and women seeking health care and benefits.

We also believe it is necessary to consider the projected expenditures under the Choice program authority that the previous Administration planned in FY 2017 and how that impacts the baseline that will dictate the funding needs for FY 2018. The previous Administration assumed as much as \$5.7 billion in spending through the Choice program in FY 2017, on top of the Medical Services discretionary funding and the newly created Medical Community Care account. That amount was revised to approximately \$2.9 billion. This means that the VA projected to spend more than \$59.0 billion in Medical Services and more than \$71.0 billion in overall Medical Care funding in FY 2017. These considerations inform the decisions of The Independent Budget to establish our baseline for our funding recommendations for both FY 2018 and FY 2019.

Earlier this year, the Administration also indicated that it intends to request as much as \$3.5 billion in additional funding for the Choice program to keep it operating at least through the end of FY 2018. That amount has since been revised to \$2.9 billion for FY 2018 (actually \$3.5 billion when considering the already available \$600 million left over from the original authorization), as well as \$3.5 billion for FY 2019 and beyond. However, this recommendation begs the question: does this recommendation suggest that the Choice program as currently designed should continue in perpetuity? Certainly no reasonable person supports that idea. We believe that Congress must reject continued funding of this program through a mandatory account and place it in line with all other community care funded through the discretionary Community Care account established previously. This will eliminate competing sources of funding for delivery of health care services in the community, while maintaining visibility on spending through the Choice program.

Moreover, we strongly oppose the decision to curtail Individual Unemployability (IU) benefits for veterans with significant service-connected disabilities simply as a means to fund the continuation of the Choice program. It is beyond comprehension that the Administration would propose such a benefit reduction in order to pay for a flawed funding mechanism for a program (Choice) that sometimes provides health care access to non-service connected disabled veterans. Does this Committee really believe that veterans with disabilities rated between 60 percent and 90 percent should be the source of funding for the Choice program? Eliminating IU benefits for veterans over the age of 62 provokes numerous questions for us. Will veterans who have statutorily protected evaluations (the 20-year rule) also be subject to reduction? Will those dependents using Chapter 35 education benefits based on their sponsor's IU rating be forced to drop out of school? Will those veterans on IU who are covered by Service-Disabled Life Insurance at no premium be forced to now pay premiums in order to keep coverage? What about state benefits, such as property tax exemptions or state education benefits that are based on 100 percent VA disability ratings? How will this proposal affect efforts to combat veteran suicide and homelessness? We hope that you will reject this proposal in the strongest terms.

For FY 2018, the IB recommends approximately \$77.0 billion in total medical care funding. Congress previously approved only \$70.0 billion in total medical care funding for FY 2018 (which includes an assumption of approximately \$3.6 billion in medical care collections). The Administration's budget request includes a not-insignificant overall medical care funding recommendation of approximately \$75.2 billion. However, we remain concerned that this level of funding will not keep pace with the continually increasing demand and utilization. The IB's recommendation also considers the approximately \$1 billion VA is expected to have remaining in the Vet-

erans Choice Fund and expected demand for care, including community care, that will not diminish or go away if the Choice Program expires. The Independent Budget recommends approximately \$82.8 billion in advance appropriations for total Medical Care for FY 2019.

### **Medical Services**

For FY 2018, The Independent Budget recommends \$64.5 billion for Medical Services. This recommendation includes:

Current Services Estimate	\$60,897,313,000
Increase in Patient Workload	\$1,595,242,000
Additional Medical Care Program Cost	\$2,001,000,000
Total FY 2018 Medical Services	\$64,493,555,000

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 1.5 percent increase for pay and benefits across the board for all VA employees in FY 2018. It was previously reported that the new Administration would like to consider a 1.9 percent federal pay raise.

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 \$1.4 billion. The increase in patient workload also includes a projected increase of 58,000 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) enrollees, as well as Operation New Dawn (OND) veterans at a cost of approximately \$242 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users through the third quarter of FY 2016.

Additionally, The Independent Budget believes that there are medical program funding needs for VA that must be considered. Those costs total approximately \$2.0 billion.

### **Long-Term Services and Supports**

The Independent Budget recommends \$535 million for FY 2018. This recommendation reflects the fact that there was a significant increase in the number of veterans receiving Long Term Services and Supports (LTSS) in 2016. Unfortunately, due to loss of authorities—specifically fee-care no longer being authorized, provider agreement authority not yet enacted, and the inability to use Choice funds for all but skilled nursing care—to purchase appropriate LTSS care particularly for home and community-based care, we estimate an increase in the number of veterans using the more costly long-stay and short-stay nursing home care.

### **Prosthetics and Sensory Aids**

In order to meet the increase in demand for prosthetics, the IB recommends an additional \$320 million. This increase in prosthetics funding reflects a similar increase in expenditures from FY 2016 to FY 2017 and the expected continued growth in expenditures for FY 2018.

### **Women Veterans**

The Medical Services appropriation should be supplemented with \$110 million designated for women's health care programs in FY 2018. These funds will be used to help the VA deal with the continuing growth in women veterans coming to VA for care, including coverage for gynecological, prenatal, and obstetric care, other gender-specific services, and for expansion and repair of facilities hosting women's care to improve privacy and safety of these facilities. The new funds would also aid VHA in making its cultural transformation to ensure women veterans are made to feel welcome at VA, and provide means for VA to improve specialized services for preventing suicide and homelessness and improvements for mental health and readjustment services for women veterans.

### **Reproductive Services (to Include IVF)**

Last year, Congress authorized appropriations for the remainder of FY 2017 and FY 2018 to provide reproductive services, to include in vitro fertilization (IVF), to service-connected catastrophically disabled veterans whose injuries preclude their ability to conceive children. The VA projects that this service will impact less than 500 veterans and their spouses in FY 2018. The VA also anticipates an expenditure of no more than \$20 million during that period. However, these services are not directly funded; therefore, the IB recommends approximately \$20 million to cover the

cost of reproductive services in FY 2018. We are pleased to see that the Administration does retain the authority to provide reproductive services in its budget proposal.

### **Emergency Care**

Recently, the VA has received serious scrutiny for its interpretation of legislation dating back to 2009, which required it to pay for veterans who sought emergency care outside of the VA health care system. The *Richard W. Staab v. Robert A. McDonald* ruling handed down by the US Court of Appeals for Veterans Claims last year, places the financial responsibility of these emergency care claims squarely on the VA. Although VA continues to appeal this decision, it is not expected to prevail in this case leaving itself with a more than \$10 billion dollar obligation over the next 10 years. The Staab ruling is estimated to cost VA approximately \$1.0 billion in FY 2018 and about \$1.1 billion in FY 2019, which the IB has included in our recommendations.

We are disappointed to see that the Administration's proposal continues to ignore its growing obligation to cover the cost of emergency care as dictated by the Staab decision. In fact, the Secretary suggested during a recent testimony before the Senate Committee on Veterans' Affairs that unfortunately the VA will have to take the money away from other places in its budget to pay these obligations. This is wholly unacceptable. Veterans should not have their benefits and services curtailed to pay for an utter failure of VA to accept this requirement. The VA should have requested the necessary funds in its Budget Request for FY 2018 to address this need. As it did not, it is incumbent upon Congress to provide the additional necessary resources. If Congress fails to do so, it and the VA will both bear the blame for the negative impact that will be experienced in other areas of the VA.

### **FY 2019 Medical Services Advance Appropriations**

The Independent Budget once again offers baseline projections for funding through advance appropriations for the Medical Care accounts for FY 2019. While the enactment of advance appropriations for VA medical care in 2009 helped to improve the predictability of funding requested by the Administration and approved by Congress, we have become increasingly concerned that sufficient corrections have not been made in recent years to adjust for new, unexpected demand for care. As indicated previously, we have serious concerns that the previous Administration significantly underestimated its FY 2018 advance appropriations request. This trend cannot be allowed to continue, particularly as Congress continues to look for ways to reduce discretionary spending, even when those reductions cannot be justified.

For FY 2019, The Independent Budget recommends approximately \$69.5 billion for Medical Services. Our Medical Services advance appropriations recommendation includes:

Current Services Estimate	\$66,334,946,000
Increase in Patient Workload	\$1,589,892,000
Additional Medical Care Program Cost	\$1,526,000,000
Total FY 2019 Medical Services	\$69,450,838,000

Our estimate of growth in patient workload is based on a projected increase of approximately 78,000 new patients. These new unique patients include priority group 1≥-8 veterans and covered nonveterans. We estimate the cost of these new patients to be approximately \$1.3 billion. This recommendation also reflects an assumption that more veterans will be accessing the system as VA expands its capacity and services and we believe that reliance rates will increase as veterans examine their health care options as a part of the Choice program. The increase in patient workload also assumes a projected increase of 62,500 new OEF/OIF and OND veterans, at a cost of approximately \$272 million.

As previously discussed, the IBVSOs believe that there are additional medical program funding needs for VA. In order to meet the increase in demand for prosthetics, the IB recommends an additional \$330 million. We believe that VA should invest a minimum of \$120 million as an advance appropriation in FY 2019 to expand and improve access to women veterans' health care programs. Our additional program cost recommendation includes continued investment of \$20 million to support extension of the authority to provide reproductive services to the most catastrophically disabled veterans. Finally, VA's cost burden for paying emergency care claims dictated by the Staab ruling will require at least \$1.1 billion in FY 2019 alone.

### **Medical Support and Compliance**

For Medical Support and Compliance, The Independent Budget recommends \$6.7 billion for FY 2018. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2017 appropriated level. Additionally, for FY 2019 The Independent Budget recommends \$6.8 billion for Medical Support and Compliance. We have concerns about the significant growth in these administrative account functions recommended by the Administration (nearly \$300 million in FY 2018 and an additional \$300 million in FY 2019) as these areas have been shown to be bloated on numerous occasions in the past. These dollars could certainly be better spent providing direct care services to veterans.

#### **Medical Facilities**

For Medical Facilities, The Independent Budget recommends \$5.8 billion for FY 2018. Our Medical Facilities recommendation includes \$1.35 billion for Non-Recurring Maintenance (NRM). Likewise, The Independent Budget recommends approximately \$6.6 billion for Medical Facilities for FY 2019. Our FY 2019 advance appropriation recommendation also includes \$1.35 billion for NRM. We are pleased to see the Administration recommending real funding for this account in FY 2018 (approximately \$6.5 billion), but we are concerned that the Budget Request reflects the continued trend of reducing the recommendation in the advance appropriation year (\$5.9 billion in FY 2019) in order to seemingly hold down discretionary projections.

#### **Medical and Prosthetic Research**

We are very disappointed to see the major cut in funding for the Medical and Prosthetic Research program in the Administration's Budget Request—from \$675 million in FY 2017 to \$640 million in FY 2018. Despite documented success of VA investigators across many fields, the amount of appropriated funding for VA research since FY 2010 has lagged far behind annual biomedical research inflation rates, resulting in a net loss over these years of nearly 10 percent of the program's overall purchasing power. The VA Medical and Prosthetic Research program is widely acknowledged as a success on many levels, and contributes directly to improved care for veterans and an elevated standard of care for all Americans. We recommend that Congress appropriate \$713 million for Medical and Prosthetic Research for FY 2018. Additionally, under the President's Precision Medicine Initiative, the IBVSOs recommend \$65 million to enable VA to process one quarter of the MVP samples collected, for a total research appropriation of \$778 million.

Thank you for the opportunity to submit our views on the FY 2018 VA Budget Request. We would be happy to answer any questions the Subcommittee may have.

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#### **Prepared Statement of Carlos Fuentes**

Chairman Wenstrup, Ranking Member Brownley and members of the Subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to present the VFW's views on the Department of Veterans Affairs' budget request.

The VFW is glad to see President Trump has proposed a six percent increase in VA's FY 2018 discretionary budget compared to FY 2017. However, we feel his proposal falls short of what VA needs to keep pace with demand for health care. The VFW thanks the administration for its commitment to community care, long-term care, mental health care, woman veterans and efforts to prevent and eliminate veteran homelessness.

However, we are very concerned that the administration's request to make the Veterans Choice Program a permanent mandatory program could lead to a gradual erosion of the VA health care system. What is more concerning is that the administration has chosen to make permanent a flawed program by ending Individual Unemployability benefits for severely disabled veterans who are unable to work due to their service-connected disabilities, and a round down of cost of living disability pay increases—a proposal which the VFW has opposed in the past and continues to strongly oppose.

The continued failure of Congress to eliminate sequestration has forced the administration to propose cuts to veteran benefits and cap GI Bill expenditures in order to expand the Choice Program under mandatory spending, instead of including the program in its discretionary community care account. In testimony before the Senate and House Committees on Appropriations, Secretary of Veterans Affairs (VA) David J. Shulkin has indicated that VA would like all of its community care money to come from one account, instead of having two separate accounts for the same purpose and not having the flexibility to use both accounts in accordance with

veterans' demand for community care. The VFW agrees with Secretary Shulkin and urges Congress to consolidate VA's community care programs and to fund such programs through VA's discretionary appropriations account.

Sequestration and its draconian spending caps limit our nation's ability to provide service members, veterans, and their families the care and benefits they have earned and deserve. The VFW calls on the Subcommittee to join our campaign to finally end sequestration and do away with a federal budget process based on the arbitrary budget caps, which significantly limit the government's ability to carry out programs that experience spikes in demand, such as VA health care. To the VFW, sequestration is the most significant readiness and national security threat of the 21st century, and despite almost universal congressional opposition to such haphazard budgeting, Congress has failed to end it.

### **Caregivers**

The VFW has heard for many years that veterans who require the assistance of a caregiver to perform activities of daily living have been rejected from the VA Caregivers Program, have been downgraded in tier level or outright kicked out of the program. These issues have led to VA implementing a moratorium on involuntary revocations from the program until VA is able to analyze the thousands of recent revocations to determine if veterans are being erroneously removed from the program. The VFW commends Secretary Shulkin for halting revocations and improving processes to ensure the program is functioning properly and implemented consistently throughout the VA health care system.

However the administration's budget request assumes a \$236 million decrease in funding for the program due to a projected decrease in the number of caregivers receiving stipend payments in fiscal year 2018. Given recent developments and the continued demand for this important program, the VFW believes funding for this important program should be increased, not decreased.

While the VFW certainly agrees that veterans who have recovered from injuries and illnesses should be put on a path to achieve independent living and no longer require the assistance of a caregiver, such decisions must be made when the veteran and the caregiver agree and not by VA employees who lack the proper training and medical expertise to make such decisions. When a decision is made to graduate a veteran from the caregiver program, VA must ensure veterans and their caregivers are given the training and resources, such as employment training and independent living counseling, to ensure veterans can properly transition from needing a caregiver to performing activities of daily living without the assistance of others.

The VFW has also said for years that the arbitrary delimitation of eligibility for the VA Caregiver Program unjustly ignores the selfless sacrifice of those who care for our pre-9/11 ill and injured veterans. Family caregivers who choose to provide in-home care to veterans who were severely disabled in the line of duty truly epitomize the concept of selfless service. They choose to put their lives and careers on hold, often accepting great emotional and financial burdens. They do so recognizing that their loved ones benefit greatly by receiving care in their homes, as opposed to institutional settings.

The VFW strongly believes that the contributions of family caregivers cannot be overstated, and that our nation owes them the support they need and deserve. The VFW sees no justifiable reason to exclude otherwise deserving veterans from program eligibility simply based on the era in which they served. Accordingly, we strongly urge the Subcommittee to swiftly consider and pass a bill to expand the VA Caregiver Program to veterans of all eras who need the assistance of a caregiver due to service-connected illnesses and injuries.

### **Major Construction**

For more than a decade, the Independent Budget Veterans Service Organizations (IBVSOs) have warned Congress and VA that perpetual underfunding has allowed VA's infrastructure to erode, while its capacity has swelled from 81 percent in 2004 to as high as 120 percent in 2010. We continue to believe that this need for space and chronic underfunding of medical services could lead VA to ration care.

The IBVSOs are working with VA to reform its construction process so facilities can be delivered on time and on budget. Previous errors must be corrected to ensure the issues in Aurora, Colorado, never occur again. However, Congress and the administration must not ignore the growing capital infrastructure needs of the Department's health care system.

When VA asked its Veteran Integrated Service Networks (VISN) to evaluate what they need to improve its facilities to meet the increased outpatient demand, VA determined that "improving the condition of VA's facilities through major construction



projects (96) accounted for the largest resource need.<sup>1</sup> Yet, the administration's major construction request for the Veterans Health Administration (VHA) is 36 percent less than FY 2017 and 85 percent less than actual expenditures in FY 2016.

When asked why VA is taking a strategic pause on major construction for VHA when its capital infrastructure continues to age and demand continues to increase, VA informed the IBVSOs that it simply did not receive the request that it needed for major construction because of sequestration budget caps. Congress must not allow VA's inability to invest in VHA's major construction to limit veterans' access to the health care they have earned and deserve by forcing veterans into VA's community care programs and eliminating the choice to receive care at VA medical facilities.

Currently, VA has 12 VHA construction projects that are partially funded that need a clear path to completion. Several projects have been removed from the priority list as candidates for public private partnership (P3) projects using recently enacted authority to combine private and public resources to fund VA construction projects. While the VFW supported Public Law 114–294, Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016, we do not believe the private sector can abrogate the federal government's obligation to properly fund medical facility construction projects.

At the top of VA's Integrated Priority List for 2018 are several seismic correction projects, which must be fixed urgently or VA will continue to risk the lives of its patients and employees in the case of an earthquake. These projects cannot take a strategic pause while Congress and VA decide how to manage capital infrastructure long-term. VA will need to invest more than \$3.5 billion to complete all 12 partially funded construction projects. What is more concerning to the VFW is that none of the nine VHA construction projects of the top 15 projects in VA's Integrated Priority List for 2018 received funding in the administration's fiscal year 2018 request. This means that VHA is not only drastically behind in funding for its existing projects, its urgently needed projects are also being ignored, which can significantly impact its ability to provide care to veterans.

The IBVSOs recommend that Congress appropriate at least \$1.5 billion for major construction in FY 2018. This amount will fund either the "next phase" or fund "through completion" all existing projects, and begin advance planning and design development on six major construction projects that are the highest ranked on VA's priority list.

### **Minor Construction**

In FY 2017, Congress appropriated \$372.1 million for minor construction projects. Currently, approximately 600 minor construction projects need funding to close all current and future year gaps within ten years. To complete all of these current and projected projects, VA will need to invest between \$6.7 and \$8.2 billion in minor construction over the next decade.

In August 2014, the president signed the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146). In this law, Congress provided \$5 billion to increase health care access by increasing medical staffing levels and investing in infrastructure. VA has developed a spending plan that obligated \$511 million for 64 minor construction projects over a two-year period.

While this infusion of funds has helped, there are still hundreds of minor construction projects that need funding for completion. It is important to remember that these funds are a supplement to, not a replacement of, annual appropriations for minor construction projects. The IBVSOs recommend that Congress fund VA's minor construction account at \$700 million in an effort to close all identified gaps within ten years.

### **Leasing**

Historically, VA has submitted capital leasing requests that meet the growing and changing needs of veterans. VA has again requested an adequate amount—\$270.1 million for its FY 2018 major medical leasing needs. While VA has requested adequate resources, Congress must find a way to authorize and appropriate leasing projects in a way that does not require Congress to pass a law to authorize individual leases. The VFW urges the Subcommittee to explore options similar to the process used by the House Committee on Transportation and Infrastructure to review and approve U.S. General Service Administration leases.

<sup>1</sup>Department of Veterans Affairs 2018 Budget and 2019 Advance Appropriations Requests, Volume IV: Construction, Long Range Capital Plan and Appendix. Long Range Capital Plan, page 8.3–8.

There are now 27 major medical leases awaiting congressional authorization, 18 of which have been waiting since FY 2016 and six from FY 2017. Delays in authorization of these leases will have a direct impact on VA's ability to provide timely care to veterans in their communities.

#### **Legislative Proposals**

As part of the budget, VA submitted a list of legislative proposals which have a budgetary impact. The VFW supports VA's proposals to amend pay caps for nurse executives; cover the cost of medical foster homes, so veterans can continue to live in the comfort of a home environment instead of being forced into institutional long-term care; convert perfusionists to title 38 employees; reimburse advance practice registered nurses for continuing professional education; make VA a participating provider by third party payers; and improve the hiring authorities for medical center and network directors.

The VFW does not take a position on the proposal to require VA medical facilities to become smoke free campuses, but we urge the Subcommittee to consider an appropriate implementation timeline for the more than 120 VA community living centers which have onsite designated smoking areas. Veterans who live in such facilities must be given the opportunity to adjust to a smoke free environment, not forced to quit and adjust to a new way of live within 90 days.

The VFW opposes the VA proposal to discontinue reducing the first party copayment obligations of veterans who have their copayments covered by their third-party health coverage. Under current law, VA is required to offset a veteran's VA copayment obligation with funds it collects from the veteran's third-party health care coverage. Doing so incentivizes veterans to report their third-party coverage to VA and ensure VA is able to offset the cost of providing non-service connected care. Discontinuing this practice would add cost burdens to veterans who, according to independent assessments, can least afford it. Such veterans could also choose to terminate their other health insurance—reducing the amount of funds it is able to collect—or forgo receiving all their care at VA, which results in fragmented care that endangers patient safety.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or the Subcommittee members may have.

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#### **Prepared Statement of Matthew J. Shuman**

SHUMAN 8 footnotes

Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee; On behalf of Charles E. Schmidt, the National Commander of the largest Veteran Service Organization in the United States of America representing more than 2.2 million members; we welcome this opportunity to comment on the federal budget and specific funding programs of the Department of Veterans Affairs (VA).

#### **Choice**

The American Legion has reviewed the President's budget request and while we fully support the Administration's proposal to increase the discretionary budget of the Department of Veterans Affairs by \$4.3 billion, we would like to draw this committee's attention to several components of this request that The American Legion calls on Congress to address.

One of the highlights of the President's budget request is a \$2.9 billion request to continue the Veterans Choice Program. The American Legion remains steadfast in our position that a consolidated community care program replace the disparate contracting and procurement vehicles that have amassed over the years at VHA to supplement care for veterans when medically necessary care is not available organically at VA.

In August 2014, President Obama signed into law the Veterans Access, Choice, and Accountability Act (VACAA). Included in that legislation was the Veterans Choice Program or the VCP. The Veterans Choice Program expands the availability of medical services for eligible veterans with community providers and was intended to be a temporary, emergency program in response to the revelation that VA medical centers were unable to serve the veterans in catchment areas who were requesting care, and subsequently created off-the-books wait lists to try and keep track of veterans who needed care but could not get an appointment in a timely manner.

The American Legion supported this program as an emergency, temporary measure and insisted on a sunset date, as did the House Committee of Veterans Affairs and other major veteran service organizations. Through increased emphasis on

eradicating all hidden wait lists and ensuring that all veterans asking VA for medical appointments were seen in 30 days or less, VA quickly exhausted their community care accounts while Choice funding remained largely untouched. Because of the funding mechanism used to support the Choice program VA was unable to adjust funding between their traditional contracting accounts, creating an unbalanced community care program that required former VA Secretary Bob McDonald to mandate that all appointment requests be pushed into the Choice program because that was the only way VA was able to spend down the appropriated funds. This caused an artificial dependence on the Choice program while preserving resources in VA's more established community care program accounts.

The American Legion calls on the President and this Congress to rededicate the funding proposed in the 2018 Presidential budget request toward supporting VA's medical infrastructure and existing community care programs, and allow Choice to terminate as originally planned.

### **Mental Health**

According to RAND<sup>1</sup> about one-third of returning servicemembers report symptoms of mental health or cognitive condition which served in either Iraq or Afghanistan and suffer from either major depression or post-traumatic stress disorder. This has increased the demand for mental health services at VA. Unfortunately, there is a national shortage of mental healthcare providers, and the shortage is projected to grow acute over the next decade. According to a recent analysis by the U.S. Health Resources & Services Administration, the nation needs to add 10,000 providers to each of seven separate mental healthcare professions by 2025 to meet the expected growth in demand.<sup>2</sup> The widening gap between demand and the supply of available behavioral healthcare providers is being driven by a greater emphasis on addressing mental health issues within primary care settings. Yet the average wait time at VA is about four days for routine appointments and urgent care remains same day<sup>3</sup> despite staffing shortages<sup>4</sup>. The American Legion calls on the President and this Congress to increase funding at VA to eradicate staffing shortages and support American veterans with the superior services they have earned at their VA medical facilities.

### **Caregivers**

The struggle to care for veterans wounded in defense of this nation takes a terrible toll on families. In recognition of this, Congress passed, 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 landmark legislation includes training to help to ensure patient safety, cash stipends to partially compensate for caregiver time and effort, caregiver health coverage if they have none, and guaranteed periods of respite to protect against burnout.

The comprehensive package, however, is 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. It is not open to families of severely disabled veterans injured before 9/11, nor is it open to post-9/11 veterans who have severe service-connected illnesses, rather than injuries, which is why we call on Congress to immediately pass the Military and Veteran Caregiver Services Improvement Act of 2017.

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 legislation to remove the date September 11, 2001, from Public Law 111-163 and revise the law to include all veterans who otherwise meet the eligibility requirements.<sup>5</sup>

The American Legion is optimistic 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

<sup>1</sup> <http://www.rand.org/pubs/research—briefs/RB9336.html>

<sup>2</sup> <http://www.modernhealthcare.com/article/20161231/TRANSFORMATION03/161229942>

<sup>3</sup> <https://www.va.gov/HEALTH/docs/DR71—062017—Pending—and—EWL—Biweekly—Desired—Date—Division.pdf>

<sup>4</sup> <https://www.legion.org/legislative/236723/legion-testifies-dangers-va-staff-shortages>

<sup>5</sup> American Legion Resolution No. 259 (2016): Extend Caregiver Benefits to Include Veterans Before September 11, 2001

to allocate the required funding to expand the caregiver program to all eras of conflict and veterans who should be in this program.

Though The American Legion is urging this Congress to expand the program, we are concerned that the FY18 budget reduces VA's caregiver program budget by over 200 million dollars. According to VA the "caregivers program cost estimate decreased by \$235.9 million [which was] driven largely by a revision, based on actuals, in the projected number of Caregivers receiving stipend payments<sup>6</sup>." Based on the Secretary's recent reversal on program reviews being conducted in several regions across the United States, The American Legion is concerned that this diminished request is premature and fails to properly budget for all eligible program participants. The American Legion is working with several caregiver families who have been notified that they are in jeopardy of losing, or have already lost their caregiver stipends, and will continue working with individuals at VA, and in the caregiver program, to ensure that no one who is eligible to enter into or remain in the program are unjustly denied.

#### **Proposed Funding Offsets**

The President's budget proposes funding expanded VA needs by reducing existing VA funding needs in other areas. In general, The American Legion opposes cannibalizing existing benefits earned by some veterans to support benefits for other veterans. Further, the proposal to eliminate the individual unemployability benefit has got to be one of the worst proposals The American Legion has heard in years and adamantly opposes this request<sup>7</sup>.

The administration's proposal would also round down to the nearest dollar the annual Cost-of-Living Adjustment (COLA) for service-connected disability compensation, dependency and indemnity compensation, along with certain education programs. The American Legion opposes any reduction what so ever in the annual cost of living increases entitled to veterans<sup>8</sup>.

The American Legion thanks this committee for the opportunity to elucidate the position of the over 2.2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Matthew Shuman, Director of The American Legion Legislative Division at (202) 861-2700 or mshuman@legion.org.

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#### **Prepared Statement of Poonam Alaigh, M.D.**

Good afternoon Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to appear before you to discuss the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) fiscal year (FY) 2018 Budget and FY 2019 Medical Care Advance Appropriations budget requests. I am accompanied today by Mark Yow, VHA Chief Finance Officer.

The 2018 budget request fulfills the Administration's strong commitment to all of our Nation's Veterans by providing the resources necessary for improving the care and support our Veterans have earned through sacrifice and service to our country. The President's 2018 budget requests \$75.2 billion for VHA—\$72.3 billion in discretionary funding (including medical care collections), of which \$70 billion was previously provided as the 2018 AA for Medical Care. The discretionary request is an increase of \$4.6 billion, or 6.7 percent, over 2017. It will improve patient access and timeliness of medical care services for over 9 million enrolled Veterans. The President's 2018 budget also requests additional mandatory funding to carry out the Veterans Choice Program (Choice Program).

For the 2019 AA, the budget requests \$74 billion in discretionary funding (including medical care collections) for Medical Care. The budget also requests \$3.5 billion in mandatory budget authority in 2019 for the Choice Program.

The budget's request for mandatory funding to continue the Choice Program, or its successor, is fully offset by proposed reductions to certain Veterans' benefits programs.

This budget request will ensure the Nation's Veterans receive high-quality health care and timely access to services. I urge Congress to support and fully fund the Department's 2018 and 2019 AA budget requests - these resources are critical to enabling the Department to meet the increasing needs of our Veterans.

<sup>6</sup> <https://www.va.gov/budget/docs/summary/fy2018VAsBudgetFastFacts.pdf>

<sup>7</sup> <https://www.legion.org/commander/237583/legion-slams-white-house-ba-budget>

<sup>8</sup> <https://archive.legion.org/bitstream/handle/123456789/5504/2016N164.pdf?sequence=1&isAllowed=y>

Increasing our focus and efforts in order to improve how we execute our mission is critical. Veterans have unique needs, and the services VA provides to Veterans often cannot be found in the private sector. VHA provides support to Veterans through various services, including primary care, specialty care, peer support, crisis lines, transportation, the Caregivers program, homelessness services, vocational support, behavioral health integration, medication support, and a VA-wide electronic medical record system. These services and supports are unparalleled. With the continued support of Congress, VA will supplement its services through private-sector health care, but we realize it is not a replacement for the services VA provides to Veterans.

We are already implementing bold changes in the agency. We are working hard to ensure employees are held accountable to the highest of standards. On May 31, 2017, Secretary Shulkin highlighted the activities and direction of the agency since his appointment in February 2017. My written statement will address those activities specific to VHA and how the FY 2018 budget request will assist in those efforts.

#### **Access to Care and Quality of Care**

VA is taking multiple steps to expand capacity at our facilities by focusing on staffing, space, and productivity. The FY 2018 Budget request provides \$72.3 billion in discretionary funding (including medical care collections). The request supports an increase in total outpatient visits - 114 million, compared to 110 million projected in 2017; provides health care to over 7.0 million unique patients - up from 6.9 million in 2017; and expands medical facilities through leasing and improves current infrastructure through non-recurring maintenance.

Veterans now have same-day services for primary care and mental health care at all VA medical centers across our system. I am also committed to ensuring that any Veteran who requires urgent care will receive timely care. We are also increasing transparency and empowering Veterans to make more informed decisions about their health care through our new Access and Quality Tool (available at [www.accesstocare.va.gov](http://www.accesstocare.va.gov)). This Tool allows Veterans to access transparent and easy to understand wait-time and quality-care measures for VA health care, a tool that is unparalleled across the health care industry. That means Veterans can quickly and easily compare access and quality measures across VA facilities and make informed choices about where, when, and how they receive their health care. Further, they will now be able to compare the quality of VA medical centers to local private sector hospitals. This Tool will take complex data and make it transparent to Veterans. This new Tool will continue to improve as we receive feedback from Veterans, employees, Veterans Service Organizations (VSO), Congress, and the media.

#### **Addressing Veteran Suicide**

Every suicide is tragic, and regardless of the numbers or rates, one Veteran suicide is too many. Suicide prevention is VA's highest clinical priority, and we continue to spread the word throughout VA that "Suicide Prevention is Everyone's Business." The 2018 Budget requests \$8.4 billion for Veterans' mental health services, an increase of 6 percent above the 2017 level. It also includes \$186.1 million for suicide prevention outreach. VA recognizes that Veterans are at an increased risk for suicide and has implemented a national suicide prevention strategy to address this crisis. VA is bringing the best minds in the public and private sectors together to improve our effort and determine the next steps in implementing the Eliminating Veteran Suicide Initiative. VA's suicide prevention program is based on a public health approach and recognition that suicide prevention requires ready access to high quality mental health services, supplemented by programs that address the risk for suicide directly. Showing its commitment to suicide prevention as everyone's business, VA now requires SAVE Training (The acronym "SAVE" summarizes the steps needed to take an active and valuable role in suicide prevention: Signs of suicidal thinking, Ask questions, Validate the person's experience, and Encourage treatment and Expedite getting help) annually for all employees at VA medical centers, and we are rolling out the training for all VA employees to include Central Office, the Veterans Benefits Administration, and the National Cemetery Administration. Every employee will be able to recognize and respond to signs of crisis and know how to expedite getting the individual Veteran into care.

As part of VA's commitment to put forth resources, services, and technology to reduce Veteran suicide, VA initiated the Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET). This new program was launched by VA in November 2016 and was fully implemented in February 2017. REACH VET uses a new predictive model in order to analyze existing data from Veterans' health records to identify those who are at a statistically elevated risk for suicide, hospitalization, illnesses, and other adverse outcomes. Not all Veterans who

are identified have experienced suicidal ideation or behavior. However, REACH VET allows VA to provide support and pre-emptive enhanced care in order to reduce the likelihood that the challenges these Veterans face will become a crisis.

### **Care in the Community**

We recognize that we must address how the Choice Program is accessed, and we are committed to streamlining and improving how Veterans can access and utilize it. We believe redesigning community care will result in a strong VA that can meet the special needs of our Veteran population. A redesigned community care program will not only improve access and provide greater convenience for Veterans, but will also transform how VA delivers care within our facilities. Where VA excels, we want to make sure that the tools exist to continue performing well in those areas. Veterans need VA, and for that reason, community care access must be guided by principles based on clinical need and quality.

Since the start of the Choice Program, over 1.7 million Veterans have received care through the Program. In FY 2015, VA issued more than 380,000 authorizations to Veterans through the Choice Program. In FY 2016, VA issued more than 2,000,000 authorizations to Veterans to receive care through the Choice Program, more than a five-fold increase in the number of authorizations from 2015 to 2016.

Looking at early data for 2017, it is expected that Veterans will benefit even more this year than last year from the Choice Program. In the first five months of FY 2017, we have seen a more than 36 percent increase from the same period in FY 2016 in terms of the number of Choice authorizations. In addition to increasing the number of Veterans accessing care through the Choice Program, VA is working to increase the number of community providers available through the Program. In April 2015, the Choice Program network included approximately 200,000 providers and facilities. As of March 2017, the Choice Program network has grown to over 430,000 providers and facilities, a more than 150 percent increase during this time period.

As these numbers demonstrate, demand for community care is high. In 2018, VA plans on a total of \$13.2 billion to support community care for Veterans. Community care will be funded by a discretionary appropriation of \$9.4 billion for the Medical Community Care account (\$254 million above the enacted advance appropriation) and \$256 in estimated collections, plus \$2.9 billion in new mandatory budget authority for the Choice Program. This, combined with a planned \$626 million in carryover balances in the Veterans Choice Fund, would have provided a total of \$13.2 billion in 2018 for community care. However, as of June 9, 2017, \$9.2 billion of the Choice Fund has been obligated and \$7.1 billion has been expended. These levels represent a significant acceleration of funds being expended from the Veterans Choice Fund, and consequently, the Secretary has updated the estimates VA previously put forth regarding when Choice Program funds would be fully obligated.

In March 2017, VA issued the highest number of authorizations in a month since the start of the program, followed closely by April and May. Over the three-month period between March and May 2017, VA issued nearly 800,000 authorizations for Choice Program care, a 32-percent increase over the same time period in 2016. As a result, VA anticipates that Choice Program funds will be fully obligated sooner than previously expected. Based on VA's latest risk-adjusted cost estimates and volume projections, the program will be unable to carry over the previously estimated \$626 million, resulting in a need for the total \$3.5 billion in new mandatory budget authority to continue the Choice Program in FY 2018. The 2018 budget proposes a funding mechanism to continue this program, or its successor, to ensure that we can maintain and improve upon the gains in Veterans' access to health care.

VA will continue to partner with Congress to develop a community care program that addresses the challenges we face in achieving our common goal of providing the best health care and benefits we can for our Veterans. We have also worked with and received crucial input from Veterans, community providers, VSOs, and other stakeholders in the past, and we will continue doing so going forward.

### **Electronic Health Record**

Having a Veteran's complete and accurate health record in a single common Electronic Health Record (EHR) system is critical to that care, and to improving patient safety. VA's current Veterans Information Systems and Technology Architecture (Vista) system is in need of major modernization to keep pace with the improvements in health information technology and cybersecurity, and software development is not a core competency of VA. On June 5, 2017, the Secretary announced that VA will start the process of adopting the same EHR system as the Department of Defense (DoD), now known as MHS GENESIS, which at its core consists of Cerner Millennium. VA's adoption of the same EHR system as DoD will ultimately

result in all patient data residing in one common system and enable seamless care between the Departments without the manual and electronic exchange and reconciliation of data between two separate systems.

Of course, VA has unique needs that are different from DoD's. For this reason, VA will not simply be adopting the identical EHR that DoD uses, but we intend to be on a similar Cerner platform. VA clinicians will be very involved in how this process moves forward and in the implementation of the system. Furthermore, VA must obtain interoperability not only with DoD but also with our academic affiliates and community partners, many of whom are on different information technology platforms.

Therefore, we are embarking on creating something that has not been done before - that is an integrated product that, while utilizing the DoD platform, will require a meaningful integration with other vendors to create a system that serves Veterans in the best possible way. This is going to take the cooperation and involvement of many companies and thought leaders, and can serve as a model for the Federal government and all of healthcare.

### **Medical and Prosthetic Research**

As the nation's only health research program focused exclusively on the needs of Veterans, VA research continues to play a vital role in the care and rehabilitation of our men and women who have served in uniform. Building on more than 90 years of discovery and innovation, VA research has a proud track record of transforming VA health care by bringing new evidence-based treatments and technologies into everyday clinical care. Innovative VA studies in areas such as basic and clinical science, rehabilitation, research methodology, epidemiology, informatics, and implementation science improve health care for both Veterans and the general public.

The 2018 Budget includes \$640 million for development of innovative and cutting-edge medical research for Veterans, their families, and the Nation. One example includes continuing the Million Veteran Program (MVP), a groundbreaking genomic medicine program, in which VA seeks to collect genetic samples and general health information from one million Veterans. The goal of MVP is to discover how genomic variation influences the progression of disease and response to different treatments, thus identifying ways to improve treatments for individual patients. These insights will improve care for Veterans and all Americans.

Chronic pain is prevalent among Veterans, and VA has experienced many of the problems of opiate misuse and addiction that have made this a major clinical and public-health problem in the U.S. As VA continues to reduce excessive reliance on opiate medication and responds to the requirements of the Comprehensive Addiction Recovery Act (CARA), VA will expand pain-management research in 2018 in two areas. VA is testing and implementing complementary and integrative approaches to treating chronic pain which builds on a successful State of the Art Conference in late 2016 on non-opioid therapies for chronic musculoskeletal pain. In a second, longer-term initiative, VA is working on other drug models and current drugs in the market to test their efficacy for treating pain. A study being developed under the Learning Healthcare Initiative is being launched that will evaluate the impact of implementing a new tool to identify Veterans at high risk of adverse effects from their opiate medication.

### **Ending Veterans Homelessness**

VA's homelessness research initiative develops strategies for identifying and engaging homeless Veterans. Researchers also work to ensure homeless Veterans receive proper housing, a full range of physical and mental health care, and other relevant services. They are using existing data to identify and engage Veterans who are currently homeless, and to develop strategies to identify and intervene on behalf of Veterans at risk for homelessness.

In FY 2018, VA is investing \$1.7 billion in programs to assist homeless Veterans and prevent at-risk Veterans from becoming homeless. Funding provided for specific programs that reduce and prevent Veteran homelessness include \$543 million for Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) for case management and supportive services to support about 93,000 vouchers; \$320 million for Supportive Services for Veteran Families (SSVF); and \$257.5 million for Grant and Per Diem program, including program liaisons.

### **Conclusion**

VA is committed to providing the highest quality care, that our Veterans have earned and deserve. I appreciate the hard work and dedication of VA employees, our partners from Veterans Service Organizations-who are important advocates for Veterans-our community stakeholders, and our dedicated VA volunteers. I respect

the important role that Congress has in ensuring that Veterans receive the quality health care and benefits that they rightfully deserve. I look forward to continuing our strong collaboration and partnership with this Subcommittee, our other committees of jurisdiction, and the entire Congress, as we work together to continue to enhance the delivery of health care services to our Nation's Veterans.

Mr. Chairman, Members of the Subcommittee, this concludes my remarks. Thank you again for the opportunity to testify. My colleague and I will be happy to respond to any questions from you or other Members of the Subcommittee.

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### Statements For The Record

#### HEALTH NET FEDERAL SERVICES, LLC

BILLY R. MAYNARD, PRESIDENT AND CEO

RE: Letter correcting 062317 Record from House Veterans' Affairs Subcommittee on Health during the hearing entitled, "FY 2018 Department of Veterans Affairs Budget Request for the Veterans Health Administration"

Dear Chairman Wenstrup,

I am writing with regard to the testimony provided by Dr. Poonam Alaigh, M.D., Acting Under Secretary of Health, Veterans Health Administration, Department of Veterans Affairs before the House Veterans Affairs Subcommittee on Health during the hearing entitled, "FY 2018 Department of Veterans Affairs Budget Request for the Veterans Health Administration" held on June 23, 2017.

During the hearing, in response to a question from Congressman Bilirakis regarding prompt payment of providers, Dr. Alaigh stated that "Our (VA's) payment to the TPAs (Third Party Administrators) is within thirty days. The TPAs then have to pay the provider."

This statement is factually incorrect. Under the Veterans Choice Program, the TPAs pay the provider claims first from their own funds then invoice the VA for reimbursement. The correct process is as follows:

- A veteran is referred to the Choice program by the VA.
- The veteran calls the Health Net Federal Services (HNFS) Veterans Choice Call Center to confirm eligibility.
- HNFS locates a VCP provider who can accept the veteran as a patient.
- HNFS schedules appointment on behalf of veteran and faxes the provider information about the appointment, including the authorization number, veteran contact details and additional details given to HNFS by VA.
- The provider treats the veteran and submits a claim (electronically or mailed) to HNFS.
- Separately, the provider faxes medical documentation to HNFS. HNFS receives and processes the claim and pays the provider.
- Only then does HNFS invoice the VA for reimbursement for the paid claim.
- On average, VA reimburses HNFS within thirty days of invoice.

Working in this way, over the last 18 months, HNFS has reimbursed community providers supporting eligible veterans located throughout the states and VA regions we are responsible for more than \$1.2 billion in paid claims - all of which has been paid by our company in advance of any reimbursement from VA. On average, our company has maintained a balance of not less than \$125 million paid in advance on behalf of the US Government in support of Choice Program health care costs. At times, the balance of paid claims we have maintained has exceeded \$250 million pending adjudication through the invoicing process of the VA.

Fulfilling our responsibilities as a Veterans Choice Program (VCP) contractor has required HNFS, with the full support of our publicly-traded parent, Centene Corporation, to make extraordinary capital commitments that are unique and effectively unprecedented for a government contractor. In fact, it is fair to say that not many companies, and certainly not many government-sector contractors, would even have the ways and means to make such advance payment commitments.

I respectfully request that this letter be submitted for the record for the June 23, 2017 Health Subcommittee hearing. Thank you for this opportunity to set the record straight. Serving the health care needs of those who serve our great country has been the singular mission of our company for nearly 30 years. We are honored every day to have the opportunity to serve our nation's veterans as a partner with the VA in the Veterans Choice Program.



Sincerely,  
Billy R. Maynard  
President and CEO  
Health Net Federal Services, LLC

