U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2019

HEARING

BEFORE THE

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

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Thursday, February 15, 2018

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

The Committee met, pursuant to notice, at 8:00 a.m., in Room 334, Cannon House Office Building, Hon. David Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Coffman, Wenstrup, Radewagen, Bost, Walz, Takano, Brownley, Kuster, O'Rourke, Poliquin, Arrington, Rutherford, Higgins, Bergman, Banks, Gonzalez-Colon, Sablan, Esty, and Peters.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. The Committee will come to order. Good morning and thank you all for being here to discuss the President's fiscal year 2019 budget submission for the Department of Veterans Affairs. This fiscal year's budget request totals $198.6 billion in VA funding, an increase of nearly $12 billion over last year. That is a huge number, and it is even more striking when you compare the growth in VA's budget to the overall Federal spending and the economy.

There is a graph in the VA budget presentation that illustrates this point. Since 2006, the VA budget is up 175 percent, while overall Federal spending increased by 54 percent, and GDP grew only 40 percent. Given the aggressive expansion of VA resources, I appreciate the Secretary's testimony emphasizing the Department's core objectives and specific foundational services that support those objectives. The Department must stay focused on their core mission to ensure resources are appropriately utilized and Veterans' care and benefits prioritized.

VA will take action on many important items in fiscal year 2019, some examples include implementation of the Forever GI Bill, an appeals modernization, and the start of what will undoubtedly be a costly and lengthy replacement of VA's electronic health record, just to name a few. Because we cannot possible cover all these important issues at length in today's hearing, in the coming weeks our Subcommittees will hold hearings on specific aspects of the budget proposal within their jurisdictions.

Today we will discuss VA's proposed budget to help ensure the Department provides better quality and more timely services to our Nation's Veterans. One priority we share with Secretary Shulkin,

VSOs, and our Senate counterparts is consolidating and improving VA community care.

This Committee has heard from Veterans, VA employees, and industry leaders about the many obstacles that prevent VA from effectively partnering with community providers to augment in-house health care services. Consolidating community care into one cohesive program that truly serves Veterans is a key investment for the future that will make every dollar spent go further.

Another important priority is the establishment of a VA asset and infrastructure review process to help the Department repurpose or dispose of underutilized buildings, allowing dollars to be spent where they make the most impact. As we have discussed many times, modernizing VA's physical infrastructure is a crucial prerequisite to ensuring the future success of the VA care system.

I was pleased to see President Trump's infrastructure plan specifically mention VA assets. VA is one of the Federal governments largest property holding entities. However, the Department's capital asset portfolio is challenging. The average VHA building is approaching 60 years old—and I know something about that number—and was designed to meet an older in-patient model of care.

Out of the 150 million square feet of real estate, nearly 6 million are completely vacant, and many more underutilized. We need a methodical and data-driven review to determine how to adapt this physical footprint to meet the needs for the future.

Lastly, but certainly not least, is the implementation of a modern commercial electronic health record. While the EHR modernization effort is necessary, it is very expensive. The contract with Cerner alone has a price tag of about $10 billion, and that does not even include the cost of updating infrastructure to accommodate the new EHR.

Implementation, support, and sustaining VistA up until the day it can be turned off—and after visiting Fairchild Air Force Base in Spokane, Washington, recently, I am not sure you can ever turn VistA off—we also have to resolve the question the new EHR's interoperability capabilities. It is unthinkable that VA could potentially spend billions of dollars on a project that does not substantially increase the Department's ability to share information with DoD or community providers.

Yet, that is exactly what could happen if VA fails to proceed in a careful, deliberate manner. Therefore, I was relieved when Secretary Shulkin paused the award process to conduct an assessment of community provider interoperability, and I look forward to discussing any updates he can provide us with on that process today.

The Department of Veterans Affairs has a sacred mission to serve those who have served our country. To date, VA is entrusted with significant resources, out-pacing those of nearly every other agency to carry out that mission. With substantial resources comes substantial responsibility to expend dollars wisely.

On that note, before I yield to Ranking Member Walz, I would like to address a report released by the Inspector General yesterday regarding Secretary Shulkin's trip to Europe last year.

Mr. Secretary, like many Members of this dais, I was disappointed in the allegations raised by this report. I, alongside Ranking Member Walz, and Senators Isakson and Tester, were

briefed on this yesterday and I have instructed my staff to request additional documentation from the IG.

I have gotten to know you well over the last year, actually two years, and I believe your intentions to serve and care for our Nation's Veterans are well clear. You have that mission at heart. With that said, as public officials, we are all expected to be held to a higher standard and be good stewards of tax dollars. I encourage you to take every step to address the findings of this report and make any changes necessary. We have got a lot of work to do on behalf of our Nation's Veterans and we cannot allow distractions like these to keep us from doing our work. I look forward to seeing your response.

To the Members here today, I encourage you to remember the importance of the topic at hand. While I understand many of you rightfully want to ask the Secretary about the IG's findings, I ask that you keep in mind we are reviewing a budget request of nearly $200 billion, and that should be the focus of our discussion today. We have a responsibility to tax payers to thoroughly review that proposal as well.

Today, the Secretary will testify that this is not a, quote, "business as usual VA budget," end quote. I look forward to discussing exactly how this fiscal year's budget request will support a transformation to a more modern, efficient, and effective VA. And I am sure we all have many questions to ask, and we are all eager to receive the Secretary's testimony, so I will leave it at that for now. And with that, I will yield to Ranking Member Walz for any opening statements that he may have.

OPENING STATEMENT OF TIMOTHY J. WALZ, RANKING MEMBER

Mr. WALZ. Well, thank you, Chairman. And as we get started today, I just like to say our heart-felt thoughts and prayers and, hopefully, our actions go out to our fellow citizens in Florida in the tragedy that once again befallen them.

And, again, I appreciate the Chairman on this, and, Mr. Secretary, I too have gotten the opportunity to know you over many years, and your intentions to help Veterans is clear. And the trust you have on this Committee is strong, but we do need to address these allegations. And whenever we have an IG report, I think it would maybe be appropriate—and I appreciate the Chairman's already moving forward with that—to have an O&I hearing in here, clear these things up.

You had three-and-a-half days to respond, which is a little unusual. Usually longer time is given to address these. And I would just say before moving onto the budget, the allegations of a potential hacking of a VA computer system with ill intent is a serious matter. I would ask you, Mr. Secretary, we are prepared to ask the Department of Justice to look into that if you think that is appropriate, and we will follow up to see if that is the appropriate action to go on.

A budget reflects the President's priorities. Many of these priorities we are going to agree upon, some of them are going to be contentious. Rounding down, taking from one Veterans group to pay to another, we know those are there. I would address, and I have

been here for much of that increase in the budget that is showing up there from 2006, and I would note several things have happened.

Twelve years of war have happened. 2003, the budget was so underfunded that Priority 8 Veterans were asked to leave the system, they came back on in 2009, adding to that. And this Committee had the courage and the moral clarity to tackle the Nehmer claims, and the Blue Water Navy issue, and that added cost. And I think it is our responsibility, and the Chairman is exactly right, account for every penny of that, understand where that is at.

But I think in the snapshot of things, that baseline where we started in 2006 was grossly inadequate from where it was, there were things that needed to be corrected, and it is just not the end money dollar. It is what we are getting for those dollars and the improvement of care for our Veterans.

Several issues. Last week, Congress passed the Bipartisan Budget Act; included a VA budget caps, raising them $4 billion; and in 2019 for rebuilding, improving VA hospitals and clinics. So $4 billion was to address VA's significant infrastructure needs and backlogs and provide additional resources to the VA system.

But this budget proposal is spending almost half of that increase on community care instead of VA hospitals. This is after we have authorized $4.2 billion in emergency supplemental funding for the VA Choice Program last year.

Between fiscal year 2017 and 2019 request, community care spending will have increased 49 percent. This is compared to 9 percent increase in VA funding care inside the four walls. Time and again Members of this Committee and key stakeholders have raised concerns over privatization of the VA. These numbers lend credibility to those concerns and you, on many occasions yourself, Mr. Secretary, said your intent is not to privatize the VA.

Huge increase in community care spending is not enough in this year's budget, you are seeking to merge congressionally mandated account that was meant to provide greater accountability and transparency—an issue that you have championed—and how much care was being spent outside the VA. Merging these accounts will muddy our understanding of how VA is delivering care to our Nation's Veterans. As an oversight body, I hope you can understand our concerns with that proposal.

At the end of last year there were over 31,000 provider vacancies and another 4,000 vacancies for logistic, human resources, and contracting positions that had not been filled because of an unofficial hiring freeze. I want to know how this budget plans to fill the vacancies, and if the hiring freeze will continue.

Additionally, President Trump's budget proposes a pay freeze for Federal employees in fiscal year 2019. I want to know how the Department expects to recruit and retain the best providers and employees when our President does not appear to value their work.

Just last week you testified in front of this Committee that your commitment to caregivers would be reflected in this budget; I did not see it. While you are willing to make astronomical requests to fund community care, you are not willing to do the same for caregiver community.

I understand action on this issue could honestly come from either side of this witness table, and the Chairman has been a champion on this. I am doing the best from our side to do the same. Care givers deserve no less in our commitment to expansion to all Veterans from all eras. The cost of this expansion is small compared to what Veterans and their families and caregivers have been forced to pay. I was pleased to finally see a request for the new electronic health record in this budget, like to make sure we are updated on it.

Here is one that is a touchy one. I notice that the budget for the IG would be scaled back 27 FTEs during 2019, leaving the OIG far short of their desired staffing level when the OIG meets increased demand for stronger oversight of VA's programs and services. Additionally, the pay freeze will prevent OIG from hiring investigators. The optics of cutting the IG today are really, really bad. So just so—it is something that I and the Chairman have championed for years together.

So I look forward to the testimony today, Mr. Chairman, our common goals are absolutely clear, our commitment to our Nation's Veterans are clear. Getting the budget right to deliver that is our job up here, and I think this Committee is up to the task. And I yield back.

The CHAIRMAN. I thank the gentleman for yielding. We are joined this morning by the Honorable David Shulkin, Secretary of the Department of Veterans Affairs. Welcome, Dr. Shulkin. The Secretary is joined at the table by the Honorable Jon Rychalski, Assistant Secretary of Management, Chief Financial Officer for the Department of Veterans Affairs. Welcome.

Mark Yow, Chief Financial Officer of the Veterans Health Administration. James Manker, Acting Deputy Under Secretary for Benefits for the Veterans Benefits Administration. Matthew Sullivan, Deputy Under Secretary for Finance and Planning for the National Cemetery Administration. And Richard Chandler, Deputy Assistant Secretary for Resource Management for the VA's Office of Information and Technology.

Mr. Secretary, you are now recognized for as much time as you may consume.

STATEMENT OF DAVID J. SHULKIN

Mr. SHULKIN. Thank you. Mr. Chairman, I want to thank you, and, Ranking Member Walz, I want to thank you for your leadership, and thank all the Members of the Committee. Many of you had a chance to come over to my office and spend some time talking about the issues, and I know all of you are very committed to the work that we are doing here today. It is why I think this is—we have the best Committee, the Veterans Committees, in the House and the Senate because we work well together in a bipartisan way.

And, Mr. Chairman, and Ranking Member, thank you for keeping the focus of today on the important work that we have. This is a big deal, getting the resources right for our Veterans. I do regret the decisions that have been made that have taken the focus off of that important work. That is why I am here, I know that is why all of you are here, we care deeply about this subject. And it

is the reason why, to keep the attention focused on the important things, that I have made the decision to reimburse the Treasury, to follow the IG recommendations, and I am committed to doing what we have to do to focus on Veterans and make this better.

Today is about President Trump's 2019 budget and the 2020 Appropriations budget. It is a very strong budget. It reflects the President's commitment to Veterans and their families. It provides the resources to continue VA modernization and to respond to the changing needs with increasing investments in our foundational services, greater access to care, effective management practices, and modernizing the infrastructure and our legacy systems.

In the written statement that I prepared, I have detailed how we plan to invest these funds by targeting certain areas for innovation and improvement. The President's 2019 budget requests $198.6 billion for the Department that is $88.9 billion in discretionary funding which includes medical care collections, and $109.7 billion in mandatory benefits.

The discretionary budget represents an increase of $6.8 billion, or 8.3 percent, over the 2018 request. This reflects an additional $2.4 billion in discretionary funding that is now available as a result of the recently enacted legislation to raise discretionary spending caps.

The recent budget caps deal, an addendum to the 2019 budget request, are important to fully fund the community care and the Choice Program. Although we are talking about fiscal year 2019 today, I would ask for your support in securing a full appropriation for the VA in 2018. As you know, VA relies on a second bite to tailor funding to our total requirements.

The budget also seizes the opportunity to expand access to benefits and services which are focused on the five priorities that I have outlined. Providing Veterans with greater choice, modernizing our systems, focusing on resources on what is most important to Veterans, improving timeliness and services, and preventing Veteran suicide. Suicide is my top clinical priority.

The budget includes $8.6 billion for VA's mental health services, an increase of $468 million, or a 5.8 percent increase above the 2018 current estimate. The increase also enables about 162,000 more outpatient mental health visits in 2019, and directs $190 million for suicide prevention outreach. It also enables us to provide emergent mental health services to members who are administratively discharged under other than honorable conditions.

The budget also enables us to effectively implement the President's July 9th executive order that supports transitioning military members with mental health services during that first critical year as Veterans. We are also targeting women's health, one of our fastest growing populations in VA, by adding almost $29 million in fiscal year 2019, an increase of nearly 6 percent over 2018.

The budget provides $1.1 billion in major construction funding as well, and $707 million in minor construction. I am proud that the 2019 request for infrastructure is the largest in the last five years. That will allow us to address VA's modernization, renovation, and aging infrastructure concerns that you mentioned, Mr. Chairman.

In IT, this budget also allows us to innovate operationally, and includes an increase of $129 million above the budget of last year to enhance Veteran access and improve the Veteran experience.

Another major project made possible by this budget is the financial management business transformation, replacing the old financial systems and providing us with a modern, innovative financial management solution. It also supports implementation of our electronic health record, as you mentioned, so we can coordinate care for Veterans who have received care not only from VA but also the Department of Defense and our community partners. The budget includes $1.2 billion to advance the implementation of this lifetime electronic health record.

The 2019 budget also makes important investments in benefit services. For example, we will hire an additional 605 personnel for the Appeals Management Office, an increase of 40 percent, to implement reforms. And also hire an additional 225 fiduciary field examiners to ensure protection of our most vulnerable population.

This budget reflects our efforts to reform business practices intended to do what is right for our Veterans and allows to continue our transformation of VA. But our responsibility does not end with simply asking for more money to support Veterans. It is our belief that by focusing on the well-being and the enhanced functioning of Veterans, conducting administrator reviews with disability compensation payment rates, and extending the stop fraud waste and abuse initiative in the benefit payments, we will make benefits more equitable for all Veterans, and wisely use tax payer resources.

Advances in treatment and medical technologies have significantly reduced the impact of certain disabilities in the lives of many Veterans. Our goal is to get Veterans better and decrease their need for compensation, and to do that we have to modernize the rating system. More importantly, Veterans and their families deserve access, choice, and control over their health care. VA is working to build an improved integrated network for Veterans, community providers, and VA employees. We call this the coordinated access and rewarding experiences in Veteran care. It will allow us to simplify eligibility requirements, streamline administrative processes, and build a high-performing network to implement new care coordination for Veterans.

As Secretary, my job is to build a modern, adaptable, sustainable VA for a changing world. More importantly, my job is to ensure that VA's benefits, their care, and policies are stronger in the future. This President's budget supports our mission at VA. In coming years these priorities will help VA maintain our commitment to our Nation's Veterans.

Mr. Chairman, I look forward to working with you and the Committee on doing what is right for Veterans, and I look forward to your questions.

[THE PREPARED STATEMENT OF DAVID SHULKIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Shulkin. And I will start by saying that, to the Ranking Member, that we have started a great discussion on caregivers, and we are going to continue that with a

roundtable. And I would like to make that roundtable bicameral so that we can get both the senators and us all in the room together. I thought it was a great start the other day. And I do see a pathway forward where we can do this right, and get this done hopefully this year, would be my goal.

On Choice, I sent all of you all, there is a great article, I still read my medical journals, and the journal, The American Medical Association, February 6, there is a great article there on ensuring timely access to quality care for U.S. Veterans. I would encourage all of you—I sent them to your office, it is just a two page read, and I would encourage all of you to read that.

And, also, Mr. Secretary, you mentioned yesterday, we talked about this. And the VA—I think most people out in the country do not realize how extensive the VA is. We look at medical care and all the facets of medical care that VA does, the benefit process which we know has gotten slowed down a little bit, and we talked about that yesterday. By hiring 605 people, I am concerned that hiring people who do not have the skill to do it will actually slow the process down.

You get someone who is a really good claims adjudicator, they may be able to look at that claim and get it off their desk in a very timely fashion. Whereas someone who is brand new will kick it into the appeals process, and this is where it gets really slowed down. So I would encourage you to make sure that those 605 people are thoroughly vetted and trained before they are turned loose on a single claim.

Information technology, electronic health record, these are all in and of themselves huge projects, but all under the one umbrella of the VA. And I do want to give, in my short period of time, a shout out to the cemeteries. One thing that the Cemetery Administration does in this country is that I have a national cemetery within a mile-and-a-half of where I live, and it is a park-like setting, it is in a reverent setting, and I want to thank you all. Every VA Cemetery that I have visited has been immaculate, and well cared for, and honored. So I want to thank you for that.

And construction. We know that VA is in the process of modernizing. We are looking at, I don't know, 6,000-plus buildings that you all—or under your purview, you are one of the largest real estate holders in the world probably. So getting that footprint right is a huge project that we have.

I am going to start out because we know that the community care, you asked us to have a Choice program put together a little sooner than we have, but assuming that all community care consolidation legislation is enacted next month, let's say we can get that done next month, how much more funding for the existing Choice program, the existing non-VA care program, and the consolidation process itself will be necessary before we implement the consolidation? My assumption is all of this funding is provided under the Bipartisan Budget Act, the new discretionary caps arrangement; is that correct?

Mr. SHULKIN. Well, as you know, the President's budget, as proposed, funds community care by putting this all in through discretionary. That would be a 9 percent increase in funding above the 2018 levels. The situation that we have right now is that without

new legislation, we have funded the Choice program through the end of this May.

And so what this President's budget does is it essentially puts more money into the 2018 budget so that we can get through the end of the year. But we do believe the legislation is important so that we can collapse this into a singular program. And that is going to be a better use of the money make it better for Veterans.

The CHAIRMAN. I think you explained to us it was about a year process to do this, correct?

Mr. SHULKIN. Yes. To transition to a new system, to integrate all of the programs together, to change the eligibility requirements to give Veterans greater choice will be about a year's transition process.

The CHAIRMAN. And I think, as you explained yesterday, that about 36 percent of VA health care is provided in the community now; is that correct?

Mr. SHULKIN. That is correct. When I arrived at VA in July 2015, it was about 22 percent, now it is at 36 percent.

The CHAIRMAN. Mr. Secretary, you announced your electronic health record modernization decision last June, and recently paused that contracting process to conduct an assessment of interoperability. What will the DoD and community operability look like in a couple years, five years, ten years? And my time is about expired.

Mr. SHULKIN. Well, I think this is a huge decision. No one has ever implemented an electronic health record change this big, so we are taking it very seriously. And given the track record of implementing big IT projects, we have to really make sure that we got this one right.

We will clearly, first of all, there are four stages of interoperability. Everyone thinks VA has an electronic health record today, VistA, we don't, we have 130 electronic health records, 130 different parts of VistA. So this will bring us to a single electronic health record within VA.

Secondly, since this proposed to be the same system that DoD uses, we will for the first time have an interoperable system with DoD. The reason I paused was because I want to make sure that those 36 percent that are getting care in the community, we can actually understand what care they got and make sure that we are doing the right job for Veterans.

So we have to make sure that we can be interoperable with dozens of different health communication systems or records out there. And that is a challenge that, frankly, the American health care system has not figured out yet. We think VA can help lead this for the whole country by making this interoperable.

The CHAIRMAN. I thank you, Mr. Secretary. My time has expired.

Mr. Walz you are recognized.

Mr. WALZ. Well, thank you, Mr. Secretary. And there is lots of issues, and we will dig down into deep ones, and many Members will ask it, but the big question we have is, is striking that balance between the care and the research in the VA versus the community care, that we all know in this room has always been there, trying to streamline it under Choice, trying to respond to some of the

issues that arose several years ago. Do we have enough money to make it until May in the Choice program?

Mr. SHULKIN. We do, until the end of May.

Mr. WALZ. How do we know that?

Mr. SHULKIN. Because we are tracking this on a weekly basis. We are on spend rate in the Choice program between $350 and $400 million. You authorized $2.1 billion back in December, and so when we do the math, and we are tracking it, we are okay until the end of May.

Mr. WALZ. Are we providing care based on the amount of money that is there, are we providing the care, and then whatever, the money will follow?

Mr. SHULKIN. The latter. We are putting the Veterans' needs first and the money follows.

Mr. WALZ. All right. We gave $4 billion for infrastructure. It appears that that money is not going to be used for infrastructure and it is going to community care. Am I reading that correctly?

Mr. SHULKIN. No, I don't think that is exactly right. And so I am going to turn to Jon to explain the $4 billion because it certainly makes sense that there has been some confusion about tracking that money.

Mr. RYCHALSKI. You are talking about the 2019; is that correct?

Mr. WALZ. Correct.

Mr. RYCHALSKI. Yeah. So I think we are asking for the money where it is most needed. And what I would point to is the major and minor construction request for 2019 is the largest in five years. As I look to the nonrecurring maintenance for the last two years, it is substantial, it was $1.9 billion and $1.4 billion. And so I think when we look at the absolute need—and I am not discounting the aging facilities—based on the funds available, we could better use that funding, frankly, in community care.

Mr. WALZ. We are talking about the $20 billion in backlog that is out there of how we attempted to handle that, and I will have to say, like many of you, I turned on my morning news one day and I saw that the President had issued an executive order on mental health care, an issue that I have been somewhat engaged in over the last 12 years. That is $500 million. Where is that coming from?

Mr. SHULKIN. Well, we were able to get that with the additional, once the budget caps—once your deal was reached, we were given an additional $500 million to be able to support that executive order. We had originally made the decision, as you know, Ranking Member, because we thought it was the right thing to do. Our focus is on suicide and we did not worry about the money, but we are fortunate that the $500 million was given to us to make sure that was done thoroughly and appropriately.

Mr. WALZ. And I am sure they are busy, we have worked on this a lot in Clay Hunt Bill, our phone number's down here, we would help, and we were under the assumption that money was going to inside the VA which all the research and the RAND Corporation shows is far more successful than mental health care outside the walls.

So probably a discussion for this Committee to have. So now what I am seeing is a request for fiscal year 2020, advanced appro-

priations is based on the baseline, it reflects close to a 50 percent increase in community care. Is that the norm going forward, we are going to start increasing 50 percent in care in the community?

Mr. SHULKIN. I don't think so. I think that we have seen a significant increase as we have begun to address the access crisis. As you know, this really was a significant crisis in 2014, we still have some access issues, and so we are getting Veterans out to be seen rather than letting them wait. That, I think we all agree upon.

I think that we have reached essentially a much slower growth rate of that, but we are doing what you said, which is we are making sure that Veterans are being cared for appropriately and then we are letting the money followed that. I do not think we are going to see the same continued rate of growth. I think what you saw here was a Choice program implemented that was complex, that people were not able to use, finally now three years later they are understanding how to use it, and that is why we saw such a big growth.

Mr. WALZ. And Choice is good, I have always supported it. If the Choice that is not being given is a VA that is funding those 30,000 positions. So we are making a choice now that, yeah, they are not going to get the VA because there is no one to see in the VA because those appointments are open. So now the alternative is, is that we are going to care to the community.

So instead of spending money to hire those 30,000 we are going to continue to shift. We have never been against trying to strike this balance, but when we appropriate $4 billion and say it is for infrastructure, and a big chunk of it is going out, when we have executive orders shifting money out after we have not seen full implementation of the Clay Hunt Act that actually went through the regular order, the will of the people, was passed and signed into law, and now we have an executive order on a Saturday morning that no of us know about, my frustration is, I think it is becoming more and more difficult, Mr. Secretary, for you to say I am not supporting privatization of the VA because it appears that you are.

And I say that non-pejoratively because if that is the best way to get Veterans care, we certainly support that. And in many cases it is, but not in the bulk of it, and not in what we are asking on the research. So I still have deep concerns that this budget is going to continue that trend without the input, without the knowledge, and I think that is the wrong approach because Veterans themselves have made it very clear they wanted that fully funded VA. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. An announcement Jon just told me here. Our caregiver roundtable is going to be March the 6th. So we are moving quickly with that.

Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman. And, Mr. Secretary, I am looking at your construction budget. You say, I think, it is $1.1 billion in major construction and $707 million in minor construction for our priority infrastructure projects and cemetery expansions.

So the last four hospitals that the VA managed each were at least hundreds of millions of dollars over budget, years behind schedule, the worst example being in my congressional district

which was a billion dollars over budget and four years behind schedule.

One of the efforts that I led in the Congress was to strip the VA of their construction management authority for building major construction projects, hospitals, at a hundred million dollars and above. I think that number is way too high. I think it needs to go way down. The same people that had their fingerprints on these four construction projects that were years behind schedules, and hundreds of millions of dollars over budget, are the same people that are in charge of construction management today in the Department of Veterans Affairs, it is unchanged. The people that have their fingerprints over this stuff are still the same people there.

I want to encourage you, without legislation—and if it requires it, we need to move it forward—that you need to find these people another job, hopefully somewhere outside of the Federal government, and you need to shift that responsibility, as we did in my hospital in my district, to the Army Corps of Engineers, to some third party outside the VA because the waste and abuse is just incredible.

Mr. SHULKIN. Yeah.

Mr. COFFMAN. Can you respond to that?

Mr. SHULKIN. Well, Congressman, you have been very vocal on that, and I think you have been right. There is no excuse for these past projects, and we cannot continue to do business as usual. The Army Corps, as you know, is involved in every one of our major construction projects now above a hundred million dollars.

But I think we need to do a different way in the future, and I think that way of the future are public/private partnerships where the private sector helps us build. That is why we are excited about this project in Omaha, Nebraska, that we are going to do a groundbreaking on, a different model of constructing VA facilities.

Four hundred million of the major construction will be for seismic improvements because we have ignored those for a long time. In terms of reorganizing and different personnel, we are committed to doing that. We cannot continue to do it the same way. We are going to be reorganizing our whole internal approach for construction, and facilities, and logistics. And the people that job is being recruited for, we are going to look for people with outside expertise, and we think you are pushing us in the right direction, Congressman.

Mr. COFFMAN. Can you comment very quickly on your idea for reducing mandatory spending in terms of disability?

Mr. SHULKIN. Yes. Our growth in this budget, the VA budget from 2006 to 2020 is increasing by 175 percent. The Federal budget has increased by 52 percent during that same timeframe. We cannot continue to do business as usual and think that the VA is a sustainable structure for decades to come, which we know it needs to be.

So we have got to look at things differently. We want our benefits to focus on getting Veterans back to independence and well-being, and all of our efforts should be to help restore the quality of life of our Veterans, and we want to change the focus of our program to make sure we are doing that. We believe it is good for Vet-

erans and that will decrease the rate of spend of our mandatory program.

Mr. COFFMAN. Well, last point. I know this is not about the IG investigation, but you issued a memorandum prior to your trip to Europe last summer; essential employee travel. Now I am going to quote from the IG report. The memorandum instructed staff that before approving any employee travel, managers must determine whether the travel is essential in order to decrease, quote, "employee travel and generate savings," end quote, within the VA.

Do you think that your trip last summer met that criteria?

Mr. SHULKIN. I do. I believe that this was essential travel. This was the Five Eyes Conference, our allies who fight alongside of us in every war; Canada, New Zealand, Australia, the United Kingdom, and the United States. We have had this conference for 43 straight years, it has been attended by every VA secretary. If the United States, as the largest of those military forces, do not go to talk about veterans' health issues—this conference was on veterans' mental health—if the United States does not participate, that ends, that conference ends.

I planned on going to it for a year-and-a-half because we plan these things ahead of time. But I do recognize the optics of this are not good, I accept responsibility for that, but I do believe it is important the United States continue its work with its allied countries.

Mr. COFFMAN. It is not the optics that are not good, it is the facts that are not good. I yield back.

The CHAIRMAN. The gentleman's time has expired.

Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman. Mr. Secretary, I want to echo the sentiments of my colleagues regarding the IG report that was released this morning. Any misuse of tax payer money is a significant breach of the trust we place in public officials, particularly those responsible for serving our Nation's Veterans.

I am profoundly frustrated that this mismanagement has interfered with our mission of building a stronger and more sustainable VA. Now it is vital that you work to restore the trust of the American people and our Veterans so we can get back to the critical work of caring for those who serve. And I, too, with the Chairman and my Ranking Member, have gotten to know you and know your dedication to the mission of this department.

I want to ask, quickly, a few questions. How does this budget address over 30,000 provider vacancies, and 4,000 additional vacancies in administrative staff, specifically in logistics, procurement, and contracting, and human services? Is the unofficial hiring freeze still in effect?

Mr. SHULKIN. There is no hiring freeze.

Mr. TAKANO. Okay. Do you support the President's proposal to freeze Federal employee pay in fiscal year 2019?

Mr. SHULKIN. I am going to take the leadership from that from the President. That would be across the administrations. I think it is essential for us to get the right people in VA, that we have competitive salaries. And I would be concerned if we fall behind in that. So we are going to use our market assessments that we have,

our ability to do that, particularly using Title 38 to make sure that our salaries are competitive.

Mr. TAKANO. I gather there would be some concern over a hiring freeze. How would a Federal employee pay freeze affect recruitment and retention in the Department?

Mr. SHULKIN. Well, you know, we are competing, particularly in health care, but in all aspects of VA, to get the very best employees. And we know where we do not have competitive salaries that our vacancies stay open or we get the wrong people into the organization. So it is essential that we remain competitive on benefits and salary.

Mr. TAKANO. Now with regard to the hiring freeze, potentially in fiscal year 2019, would you be willing to ask the President for a waiver if you felt that the needs of the VA were so affected?

Mr. SHULKIN. I certainly would. The first thing I would want to do is to make sure we are maximizing our authorities under Title 38 and Title 5. But if it got to the point where I was not able to recruit the people that our Veterans deserve to have caring for them, I would absolutely ask for a waiver.

Mr. TAKANO. I am pleased to hear that. When I recently met with management from my local medical center, they said that they were having difficulty recruiting and retaining housekeeping staff because pay was too low. Now housekeeping staff may not be the most glamourous position, but it is absolutely vital to keep facilities clean and ensuring patient safety, and you know that in many cases the cleaning staff have to be specially trained around biohazards and all that. Won't a pay freeze exacerbate this problem and endanger patient safety?

Mr. SHULKIN. There are a number of occupations within the VA, I think housekeeping, environmental services is one of those, where when you clean a hospital, this is not the same—I think you are saying this—this is not the same as cleaning an office building. Making sure that people understand the type of microorganisms that live in hospitals, and the reason why you have to clean these environments, is lifesaving.

And so we are working to change the job specifications and the grades of these jobs so that we can be competitive. But we have a big problem hiring enough environmental workers right now. So we have to change that.

Mr. TAKANO. Won't a pay freeze exacerbate this problem and endanger patient safety?

Mr. SHULKIN. If we did not change the grade of that position, that would, yes.

Mr. TAKANO. Yeah. What resources do you need to ensure these vital positions are filled?

Mr. SHULKIN. Well, we have to get more nimble about how we grade these positions and how we change as, essentially, the outside world changes, and we need to make our hiring practices easier to be able to get the right people on board. This is work that is underway now in the transformation of VA.

Mr. TAKANO. We have heard reports that human resources personnel at local facilities were directed by VA central office to not proceed on salary surveys for jobs despite significant vacancies at facilities; is this true?

Mr. SHULKIN. If that is true, let me make it clear right now, that should not be followed. We want our facilities to do the market surveys, they need to be competitive, we have to fill these vacancies, there is no hiring freeze. Our people who work in our facilities are our most valuable asset, and we have to make sure we have the right people serving Veterans.

Mr. TAKANO. Mr. Chairman, my time is up. Could I ask one more question, or?

The CHAIRMAN. Yes, sir.

Mr. TAKANO. In many cases, like the DC VMAC and the failed medical surgical prime vendor program, vacancies in staff and leadership positions directly contributed to the postponement of procedures and effective patient care. How does this budget address vacancies for procurement, HR, and logistics personnel?

Mr. SHULKIN. Well, this fully funds our needs, and people should be filling those positions. And I think you are right that in the case of the DC VA they were understaffed, we had to bring in a large number of new people in procurement. Human resources should not be under resourced. Without that, the rest of the organization does not work.

Mr. TAKANO. Thank you very much.

The CHAIRMAN. I thank the Gentleman for yielding. And the Ranking Member and I were talking. I think part of the problem with staff in the VA, it is not VA it is countrywide. We have at home, our hospital at home, is having a terrible time filling nursing positions and other positions, it is not just hospitals but it is business in general. The jobs are out there if we can find the trained people.

Chairman Bost, you are recognized for five minutes.

Mr. BOST. Thank you, Mr. Chairman. Mr. Secretary, you know we—there are some concerns right now as the new appeals process goes into place that the VA will prioritize and fill, or go after the new system, those newly filed appeals and then kind of walk away from the old legacy appeals. You know, I note in the President's budget that the request for additional 605 full-time equivalents dedicated to VBA appeals. How many of those FTEs will the VA dedicate to processing legacy appeals?

Mr. SHULKIN. Okay. That is a great question. Jamie, do you want to take that?

Mr. MANKER. Sure.

Mr. SHULKIN. Jamie is from VBA.

Mr. MANKER. So that is a great question, thank you for it. The first thing we are doing to address legacy appeals is we are giving the appellants the opportunity to opt into the new appeal process as we speak. What we have done is we have undertaken a process where we have gone to the appellants who have had the longest appeal and said, you have the first opportunity to opt in. And we are going along several thousand a week, sending letters to the appellants and to their powers of attorney, and telling them that they have the opportunity to opt in.

Mr. BOST. Okay. But that is not my question. My question is, of those 605, how many are now going to be dedicated to clearing up the old backlog? Are they specifically going to be that, or is it just going to be across the board, or?

Mr. MANKER. So all of our appeals personnel will be working appeals. So we will have roughly 2,005, I believe is the number of appellants afterward.

Mr. SHULKIN. Yeah, but he is not talking about appeals, he is talking about the legacy—

Mr. MANKER. The legacy.

Mr. BOST. The legacy claims.

Mr. SHULKIN. So they are making progress in this. I do not think any of those are going to the legacy claims. But what they have done is they have implemented something called a new type of claim, a DRC claim, that gets this done in 38 days instead of the usual several hundred days. And so they are making great progress on the claims.

Mr. BOST. But I am still concerned about this—

Mr. SHULKIN. Yeah.

Mr. BOST [continued].—and this is across the board as we work through that Committee, the concern that we have is these legacy appeals we are trying to catch up on—

Mr. SHULKIN. Yes.

Mr. BOST [continued].—you are asking for 605 more employees.

Mr. SHULKIN. That is right.

Mr. BOST. We have got to speed the process up. Is that going to speed the process up to answer these appeals and get them taken care of?

Mr. MANKER. Absolutely, it will speed the process up. We have more, if you will, more FTE to work appeals, and we will both—we will do a blended approach to working those appeals.

Mr. BOST. Okay.

Mr. MANKER. Both the legacy appeals and the new appeals—

Mr. BOST. Because I think it is a concern of our Committee that, you know, it is one thing to handle the new ones—

Mr. MANKER. Sure.

Mr. BOST [continued].—but these people have been a long time, folks.

Mr. SHULKIN. That is right.

Mr. BOST. And the concern that we see out there, and the weight on their families trying to get an answer, the reason for changing it was to try to straighten it up. My hope is that they are aggressively on this.

Mr. MANKER. And absolutely. And as I indicated earlier, we are giving the opportunity to opt into the new process those that have been waiting the longest in the appeal line, if you will.

Mr. BOST. Okay. Mr. Secretary, you said you do not think any of them are going to go to the—

Mr. SHULKIN. The 605 are—I think as Jaime said—are going to be focused specifically on addressing the appeals, not on claims.

Mr. BOST. Okay.

Mr. SHULKIN. Right?

Mr. BOST. Okay. Yes.

Mr. SHULKIN. Yeah.

Mr. BOST. So, okay. I want to go to another quick question because, you know, you know the problems we have had in my district with Marion VA, right now the President's budget has requested $172 million for the Office of Inspector General to

strengthen accountability. I have two questions. One, was this level of funding sufficient to properly inspect and keep up with the problems that are in the VA? And, second, do you need new authority to establish clear-cut qualifications for positions like HR?

Mr. SHULKIN. Yep. On the Inspector General. My understanding—and, Jon, I am going to ask you to confirm this—is that they increased the levels last year, and this allows them to continue what they raised last year; is that correct?

Mr. RYCHALSKI. So I think what happened is they

had under-executed their program previously, they had some carryover funding, so they hired people sort of above their baseline funding level. And the—

Mr. SHULKIN. Last year?

Mr. RYCHALSKI. Correct. And then so the sustainment funding for that was less than what they had hired above, so they requested an increase. They did receive an increase. And what I would say, though, just subjectively, I absolutely support a strong IG, obviously I worked in the financial realm. But I think that we need to look at what the requirement is. We have a manpower office because I think you can't have just self-determined need, it has got to be validated somewhere.

Mr. BOST. I think if you look at the line on that it actually decreased.

Mr. RYCHALSKI. The IG's total budget?

Mr. BOST. Yeah. The FTE.

Mr. RYCHALSKI. Right. FTEs, that is why I just sort of described how that occurred.

Mr. BOST. Okay.

Mr. RYCHALSKI. They hired above their baseline funding with carryover funds. And so they hired more than they had money for in one year and they requested the additional funding. They received some of it, but they still hired above what their funding level was. My point is that the actual need should be validated. It could be what they say, it could be more, it could be less.

Mr. BOST. Okay. Thank you. My time has expired. Thank you. I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Mr. Secretary, I wanted to focus a little bit on the open nominations. I think there is clearly a lack of consistent leadership within the VA that I think is a barrier to many of the challenges that the VA faces. And at least the last I heard, there is 8 out of 22 leadership positions in VHA that are being filled by individuals in an interim or acting role.

I know that we do not have an Under Secretary for health, we do not have—a permanent one anyway, Under Secretary of health or Under Secretary of benefits. What progress are we making in terms of finding candidates to fulfill longer term leadership within the VA?

Mr. SHULKIN. Yeah. I appreciate that. I think I share that same concern, it is taking us too long to get these positions filled. The Under Secretary for Health, we had our third round of commissions. In other words, this is the third time we have had to have

a commission interview candidates, that was on Tuesday of this week.

Yesterday I was given three names from the Commission, so they completed their work. I am in the process now of evaluating them. And then we will make those three names, if they are vetted through, to the President for a nomination. So I am hopeful on that.

The Under Secretary for Benefits, the Commission did meet. We did submit three names to the President, and they are in the process now at vetting those candidates at the White House. The CIO position, in a similar way where we have submitted some names to the White House and they are vetting them. So this is a long process, takes too long, but I feel like we are making specific recommendations to be able to get these positions filled.

Ms. BROWNLEY. Are you waiting for these positions to be filled for those folks who are in the position to then hire and fill other important sites?

Mr. SHULKIN. No. No.

Ms. BROWNLEY. Thank you. I share the concerns and the line of questioning that my colleague Mr. Takano asked. And, to me, in terms of these many, many vacancies throughout the VA, one of the—I think the heart of the issue is predominantly around lack of human resource personnel. And I just need to hear from you a commitment that you have a sort of a laser sharp focus on filling these positions so that they can roll up their sleeves and get down to work to actually fill these other very critical positions across the country.

Mr. SHULKIN. Yeah. I agree. I would be concerned if anybody out there believes that there is a freeze or any desire not to completely staff your human resources office. That is, I agree with both of you. This is a critical area to make sure that we are fully staffed in.

Ms. BROWNLEY. I mean, I know within my VISN in Southern California that, and beyond, but that is the primary issue is—at least when I ask the questions, it is because human resources is not able to fulfill their responsibilities on a timely basis. So I wanted to ask in terms of the President's executive order on mental health in the community. What does the implementation of that look like?

Mr. SHULKIN. We are planning on presenting a detailed plan back to the President March 9th, that will be 60 days after the President issued executive order. What that looks like is, pre-enrolling the servicemembers before they leave on the last day of service so that they do not have to wonder how they get access to benefits, that they already have them right there.

Offering an initial, what we will call an introduction to the benefits and the services that every servicemember would have so that they understand that asking for help and getting the type of services that are offered at the VA is available to them. We plan on using peer counselors because we feel that is one of the strongest ways to help people understand about how what they are going through and how they might get help. And providing expedited access to those that need help at the right time.

Ms. BROWNLEY. And when that plan is complete, and you present it to the President, will you also present it to the Committee?

Mr. SHULKIN. Yes. Absolutely.

Ms. BROWNLEY. Thank you. I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

I now will yield to my good friend Dr. Wenstrup, who I overlooked in the last questioning. He can have as much time as he wants to consume.

Mr. WENSTRUP. We will stick with the five minutes. Thank you. Mr. Secretary, in the idea of flexibility and being able to make decisions that make sense we take a look at our unused or underutilized assets, and I think there is 131 vacant or mostly vacant buildings that have been repurposed or disposed of. And I am wondering how much revenue we have gained from that, or did it cost us more to get rid of them in the short term but maybe save in the long term, could you give me some insight on that?

Mr. SHULKIN. Yeah. No, I think you are correct. It often—part of the reason why these buildings remain standing, and vacant, and become problems is because it sometimes takes capital to knock them down and clear the site, but we have started to do that.

The recurring savings from those 131 buildings is about $7 million a year. In some cases, we have had to invest some money to be able to remove those facilities or get rid of them, but it is overall a savings. The infrastructure bill that the President has just introduced, when they talked about VA, will allow us to use those savings, or if we sell the buildings, to reinvest in VA infrastructure. So we are very grateful for that provision which has not existed before.

Mr. WENSTRUP. So that leads to my next question. You are tracking that particular amount of money, if you will, and where it is going. Now is it going strictly to new infrastructure, to modernization? What is the plan there?

Mr. SHULKIN. Right. Well, currently today if we exit a property that money gets returned to the U.S. Treasurer, we are not able to reinvest that. The infrastructure bill would change that. So that is why we are very supportive of that. What we do save are the recurring savings, the maintenance. So we do not heat the buildings, we do not have to repair them if we get rid of them. That, remains in our general, what we call our NRM budgets, our recurring maintenance budgets.

Mr. WENSTRUP. Do you think there will be a way to in some way get an idea of how it is converted, directly or indirectly, to care or—

Mr. SHULKIN. Yes.

Mr. WENSTRUP [continued]. —Veteran services?

Mr. SHULKIN. Yes. Yes. And what we would plan on doing is reinvesting that money back into probably NRM or minor construction projects.

Mr. WENSTRUP. Okay.

Mr. SHULKIN. We could track that.

Mr. WENSTRUP. Thank you. Another question I have is, one of the things that budget talks about is foundational services and service-connected disabilities, but then the list includes geriatrics and primary care, all part of the mission. I guess I am trying to understand what we consider foundational services, service-connected, if you can give me some clarity on that.

Mr. SHULKIN. Yeah. We have spent a lot of time on this, Congressman, and, clearly, this is about making sure that those things that the VA needs to do well for its—for the people who have served, we are doing in a world-class way. And so there is no doubt things like spinal cord injury, and blind rehabilitation, and post-traumatic stress, and focusing on the suicide issue, and other things clearly are foundational services.

But as part of the VA definition of health, how we do this, we do believe a system of strong primary care, geriatrics care as a primary care specialty of older people, women's health, as well as mental health is the foundation of what a strong integrated system needs to have.

We do not need to be doing everything, and we do not—we cannot do everything well, we have learned that in the past. But these services, every VA facility needs to be focused on to do in a world-class way.

Mr. WENSTRUP. Thanks for that clarity, and I would tend to agree because something that may be clearly service-connected cannot be treated as efficiently if you do not have proper primary care. So I think that is what you are saying.

Mr. SHULKIN. Yes.

Mr. WENSTRUP. Thank you. And I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. O'Rourke, you are recognized for five minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Secretary, I wanted to begin by thanking you for your focus on reducing Veteran suicide. You mentioned that this is your number one clinical priority. You are the first VA secretary, to my knowledge, to make this such a high profile issue. And I am convinced that as we acknowledge the problem that we have, and by your estimate it is 20 Veterans a day every single day are taking their lives.

We know that for those Veterans who have an other than honorable discharge—hundreds of thousands of U.S. Veterans have an other than honorable discharge—tens of thousands of them were diagnosed with post-traumatic stress disorder, or traumatic brain injury, or other conditions unique and caused by their service who are effectively denied access to VA health care.

I know you have worked with Congressman Coffman, and myself, and others to try to expand access and thereby save more lives. In El Paso we know that there is a correlation between the number of mental health care providers and access to mental health care help and reducing Veteran suicide.

We went from 68 full-time mental health care staff to today 122. More Veterans are getting care, they are waiting fewer days to get in to see a psychologist, or a psychiatrist, or a therapist, and I know you have personally taken an interest in this and helped us to do that. So I want to thank you.

So to that point. If there are 30,000 authorized appropriated for unfilled clinical positions, how many of those 30,000 positions are psychiatrists, and psychologists, therapists, neurologists, others who will help with the unique conditions connected to service, the unique conditions that are too often connected to Veteran suicide?

Mr. SHULKIN. Yeah. Last year we hired 763 psychiatrists and psychologists. Unfortunately, it was only a net of about 260 because—

Mr. O'ROURKE. Retirements.

Mr. SHULKIN [continued]. —retirements, and people sometimes choose to find other places to work. So we have a need right now for at least a thousand new mental health professionals in this fiscal year, and we focused on trying to hiring them. The budget allows us, with an increase of close to $500 million in mental health funding, to fund for an additional 162,000 mental health visits. And when you look at how you would have to staff that, that is about a thousand mental health professionals.

Mr. O'ROURKE. How many of the 30,000 unfilled clinical positions are primary care providers?

Mr. SHULKIN. I do not have an exact number, but my guess is, is that we probably are—when you say primary care providers, I am going to talk about advance practice nurses too as well as family doctors and internists.

Mr. O'ROURKE. Let me do this because—

Mr. SHULKIN. Yeah.

Mr. O'ROURKE [continued]. —both answers are very important to me.

Mr. SHULKIN. Yes.

Mr. O'ROURKE. And I am going to hang out until the end of the hearing. I know your team in your office is watching this.

Mr. SHULKIN. Yes.

Mr. O'ROURKE. Have them get you the number, I will wait, I want to make sure everyone here knows.

Mr. SHULKIN. Thank you. Let's do that.

Mr. O'ROURKE. This is a priority, let's understand what the delta is and we are all going to do to bridge that gap, and the hiring, and the resources, prioritizing for those hires. Do you think that a Veteran's primary care provider should be in the VA?

Mr. SHULKIN. I think that—my preference would be that we have—since VA uses a different model of primary care does not—in the outpatient environment, where I am a primary care provider in the private sector, patients are usually seen about every 15 or 20 minutes. The VA gives a longer period for a more comprehensive evaluation. And our definition includes behavioral health integration, it looks at military issues in a broader way. So I believe primary care providers need to have a military competence when they see—

Mr. O'ROURKE. So is that a yes, we want Veterans because—

Mr. SHULKIN. Or they need to be trained well if they are in the private sector.

Mr. O'ROURKE. Well, let me make the case—

Mr. SHULKIN. Yeah.

Mr. O'ROURKE. —and I hope I can get you to agree that if we make the VA central to the Veteran's care, we understand they may need to be referred out if there is not capacity or specialization within a given VA, but if we make the VA central to that Veteran's care, that VA provider will know the signs to look for suicidal ideation, they have taken care of other Veterans and servicemembers, that they are going to have a higher proficiency and a greater level

of experience taking care of those Veterans, and I think those Veterans are going to get better outcomes as a result.

And so I would just request that that be, if it is not today, and it sounds like it is unclear, I think that needs to be VA policy, and a VA priority. And I would add that I think for those treatments that are unique to service and combat—post-traumatic stress disorder, traumatic brain injury, traumatic amputation, spinal cord injuries—that has to be within the VA.

I would ask you to prioritize your hiring for those specialty, specialists, and primary care providers who ensure that care for the Veteran is anchored within the VA. I share some of the concerns that others have raised, including Veterans who come to our town halls, that there is a move to privatize care. I want that care centered in the VA. And so I am going to await the answers to the specific questions I asked on hiring, hopefully you can get those to us before the end of the meeting.

Mr. SHULKIN. I hope you are right that they are watching so that we can do that for you because I agree, it is better to have good numbers. But what you just described is—and you did it much better than I did, so thank you—is exactly our strategy around foundational services. You focus on the things that Veterans really need us to be good at. So, absolutely, I agree with your description.

The CHAIRMAN. The gentleman's time has expired.

I would argue also that a VA primary care physician who has never served would not be as well prepared as a Veteran like myself, who is a military doctor who retired from the military, would understand also. So there are people on the outside who can provide those services. Like Dr. Wenstrup, myself, and others who have served in the military certainly understand those needs.

Mr. Higgins, you are recognized for five minutes.

Mr. HIGGINS. Thank you, Mr. Chairman. And I thank the Secretary for appearing today. I thank you for your continued dedicated leadership, sir. I will remind those present, including the media, and my colleagues that the Nation of American Veterans for 242 years have fought to establish and maintain a Nation of laws. A Nation where a man is considered innocent until proven guilty. And I would hope that we are not sliding towards a Nation of allegation and accusation.

Regarding extended care facilities, sir. I see in the budget that there is a 66.7 increase request for grants for state extended care facilities, and a zero percent request for grants for Veteran cemeteries. There seems to be disconnect there.

I am concerned about our Veterans, especially our aging Veteran population, as we attempt to provide for these Veterans who, in same cases, certainly our Vietnam Veterans, did not return to warmth and open arms from that Nation, from a Nation that they served at that time. And these are the same Veterans that are not cared for in the caregiver program, and they are approaching their golden years, their last years on this earth.

So an extended care facility and a long-term care facility, I would think that we would at least seek to provide for our aging Veterans end of life period of dignity where they can be revered and visited by family in their community where they live. And I just see a disparity in budget, sir. Would you please address that?

Mr. SHULKIN. Yeah. Well, we did significantly increase the amount of funds available to the state homes where 50 percent of the Veterans are being cared for right now in the state homes. I met with all those directors this week, and they are extremely grateful for the support that we are providing for them to be able to do that work because the number of Veterans who are aging, of course, is increasing. On the cemeteries, we have, I think, it is a $334 million increase in the fiscal year 2019 budget. Right?

Mr. SULLIVAN. Sir, we do have a large increase in the fiscal year 2019 budget to address major construction and minor construction for national cemeteries. The grants program is a flag request, but that grants program amount is adequate for funding. Historically, the grants that are on the priority list that do have the matching funds and the assurances necessary to provide a grant award for the fiscal year.

Mr. HIGGINS. So you feel that the funding that is in the fiscal year 2019 budget request is sufficient for states to perform at that level—

Mr. SULLIVAN. Yes, sir, I do.

Mr. HIGGINS [continued]. —for servicing an aging Veteran population that, obviously, the next stop from extended and long term care is a cemetery. And it would be our goal amongst this bipartisan Committee, it should be our goal as a Nation, to provide our Veterans with end of life dignity, and that would include appropriate services, military services, patriotic services, and to be buried amongst their Veteran brothers and sisters.

Mr. SULLIVAN. Yes, sir, that is exactly the mission of the National Cemetery Administration. And we work with our state partners to operate this network of our 135 national cemeteries as well as 107 grant-funded state cemeteries to provide that national shrine for final resting places for our Nation's Veterans.

Mr. HIGGINS. Thank you. That is an encouraging answer. Quickly, Mr. Secretary, VA witnesses have testified previously that non-institutional care settings are more cost effective than institutional care settings. This budget allocates $556 million as a, quote, "continued investment in non-institutional settings." How exactly will this budget invest in non-institutional care settings?

Mr. SHULKIN. We are, as you know, I think this is exactly correct, that we believe that it is often better to allow people to remain in their home and look at alternatives, even things like adult day care, which we want to make easier for Veterans to get access to.

But with the advances in technology like TeleHealth remote monitoring, our aids and attendants program, our home care visit programs, we have a package of services that is now a priority focus for us to make sure that we implement that. And we are supportive, as I know you are in our last discussion, about expanding caregivers to older Veterans. And we think that is an important piece of this as well.

Mr. HIGGINS. Thank you. Mr. Chairman, my time has expired.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you. Thank you very much, Mr. Chairman. And welcome, Mr. Secretary, we are happy to have you with us,

and I appreciate your comments at the top, and I do think it is important to restore confidence in our executive officials, and so I hope in the coming days you will be forthcoming with the American people.

I want to turn to the issue of coordination of care and collaboration. Mr. Bilirakis and I will be introducing a bipartisan bill today that is a pilot project for integrating Veterans' care in our federally qualified health centers, FQHCs. And in my area where we have a rural northern part of the state, often the FQHC is the place that people can get access to care without traveling long distances. Could you comment on that issue or other collaborative ventures that the VA is getting into?

Mr. SHULKIN. Well, thank you for introducing that. I am not sure people recognize around the country just how important these federally qualified health care centers are. They do amazing work for a very vulnerable population. And I believe that as a large provider, or Federal health care services, that these organizations should look for the chance to collaborate more and to integrate in ways that we really have not in the past. So I think that a pilot program in that area would be very productive.

Ms. KUSTER. Excellent. Thank you very much. And we will look forward to working with your team on that as we go forward. I want to focus in on the leadership structure in the VA. You know we have had issues in New Hampshire around Manchester Veterans Hospital, we have learned of some very serious concerns in Bedford, Massachusetts, at the VA hospital. And my biggest concern is I do not see the VISN stepping in in an effective way when there are problems in our VA hospitals.

Do you think we might have come to a time where we need to change this VISN organizational structure, and particularly with regard to hospital leadership and their report direct into your team as compared to a VISN that maybe is not sufficiently responsive?

Mr. SHULKIN. Well, first of all, I appreciate you sharing these concerns as you have. You have been a very strong advocate for getting this issue right. Our VISNs were introduced, the concept of VISNs, over 15 years ago. Yes, it is time to take a look at how modern health care system operates. And that is what we are doing in our modernization work.

We have looked at large health systems like Kaiser, Ascension, Trinity that have multiple hospitals throughout large regions, and how they are organized, and we are looking at those best practices and seeing what we need to do. The basic strategy, though, is, we have to give the people running our facilities, our medical center directors, more authority and accountability to be responsible for the decisions. And we have to look at what then the role of the VISN is, and how that modernizes.

Ms. KUSTER. I appreciate that. And, again, look forward to working with your team on reviewing that structure as it—particularly focusing in on hospitals where this has not been an effective—

Mr. SHULKIN. Yes.

Ms. KUSTER [continued]. —oversight structure. So I appreciate that. In my last minute-and-a-half, I would love to hear your thoughts on, it looks as though you have created a new account for

the VA modernizing the electronic health records system, and I want to drill down a little bit.

Is this new account, will it include funds to support and maintain the current VistA electronic health record during the modernization process or will these funds only be used on the adoption of an implementation of the Department of Defense electronic health record that we are adopting? If you could walk us through how those two things will be funded at the same time.

Mr. SHULKIN. Yeah. It has to be both. This is going to—in order to implement a new electronic medical record, we are going to have to invest in the infrastructure of our connectivity, of our servers to get ready to do that. We are going to have to undergo significant change management because when you implement the EHR it is about technology but only a little bit, this is about how you do business.

So we are going to take 130 different systems and we are going to really be creating a single instance. That is a major change. It should create great efficiencies, improvements, and quality as well. And so we are going to be focused on maintaining VistA because we have 130 transitions to happen. So that is why over a ten year period of time, you are going to be running VistA up until that very last instance is turned over.

Ms. KUSTER. So my time is up, but I hope you will keep the Committee informed of your timeline and your progress as you go forward.

Mr. SHULKIN. Yes.

Ms. KUSTER. So, thank you, and I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

And just to comment about this, and I think we will get into this more as we go along. The distressing part for me when I was at Fairchild was, I am not sure you are ever going to be—as a long a current Veteran that is in the old, when you get to the new system that is fine, in the old system—you will ever be able to turn it completely off for 50 years. Because until the last of us die that are in that old system, there is no way to download all—there is so much information in the VistA system—they can't download all that information. So you have to have a way to look back to get information. I do not know how complicated that will be, but it is a major undertaking to do what they are doing.

Mr. Banks, you are recognized.

Mr. BANKS. Thank you, Mr. Chairman. And thank you for being here, Secretary Shulkin. First and foremost, I am enormously proud of what we have accomplished in partnership with this administration. President Trump, under your leadership, this Committee, over the past 14 months, we have done a lot of great work for Veterans that we should be proud of. And I appreciate the seriousness that you have taken the IG report and addressing it, and I look forward to continuing to see you do that.

To dive a little bit deeper into Ms. Kuster's question. I know that you agree that Veterans deserve a scheduling system that gives them immediate access to care, shortened wait times, the ability to track and manage information and progress throughout the care continuum. I want to make sure, though, that as we appropriate

money and pass budgets that the money that we provide to the VA is effectively utilized, which is the reason that you are here today.

And we have seen this past year that with the electronic health record roll out that has run into trouble, we have seen the delay of implementation even further. So my question is, with a readily available COTS, solution, and the appointment scheduling system, or MASS, program that can be deployed nationally in a two-year timeframe, what are your plans and timeline, to be a little more specific, to utilize funds you receive for IT improvements to pay for a full deployment that is not dependent on the stalled ten-year VA EHR rollout?

Mr. SHULKIN. Specifically on scheduling?

Mr. BANKS. Yes. IT.

Mr. SHULKIN. Yeah. Yeah. Yeah. The strategy that we are using now is to move towards COTS or off-the-shelf products, and there are plenty of good commercial systems that are out there. The MASS scheduling system is being implemented right now in Columbus, Ohio, and we look very much forward to seeing how that is working.

That pilot is on track to be—do you remember the live date that that will go in Columbus?

Mr. RYCHALSKI. I do not, sir. I think it is March.

Mr. SHULKIN. Yeah. Yeah, it should be in the next few months that this goes live, and we are very much looking forward to seeing how that is working. We have some other COTS, products that are being tested in three other sites—I think Bedford is one of them—that we are very much looking forward to seeing how that is working as well.

In the meantime, we have rolled out to right now it has gone to 35,000 different Veteran transactions an internal system called Veteran Scheduling Enhancement. But I think our plan is to go towards an off-the-shelf product.

Mr. BANKS. Okay. Thank you. Please keep us posted on that.

Mr. SHULKIN. Yes.

Mr. BANKS. Earlier this year, on a different subject, I was disconcerted when the VA considered taking funds from homeless program case managers and converted them into general purpose funds. I know you and I, and others on your team and I have talked about this. I appreciate the motives of wanting to provide flexibility to the VISN directors, but I do not believe that this should come at the cost of assisting the Veterans who are most in need. I know that you agree with that.

Especially because if less Veterans find their footing into stable situations, we will be spending more money and not saving money. And for fiscal year 2019 it appears the VA intends to revisit this possibility once again by soliciting stakeholder input first, which is a healthy part of the process. So, if stakeholder input remains opposed to this change as it was overwhelmingly for fiscal year 2018, can you guarantee today that the VA will not go execute this change in homeless programs affecting fiscal year 2019?

Mr. SHULKIN. The mistake that we made was letting anybody think that we are taking the foot off the pedal on ending Veteran homelessness. We are not, we are laser focused on this, this is a

commitment. We have $1.8 billion in the President's budget for ending Veterans homelessness.

What we are trying to do, when you look at the data, as you know, Veterans homelessness actually went in the wrong direction last year, it went up 2 percent, but there were five specific cities that led to that increase. Two of them, which are Seattle and Los Angeles, were by far the overwhelming increase.

We wanted to find a way to be able to use this $1.8 billion to focus on where the Veterans are having the most problems. We need stakeholder input, we need to do it thoughtfully before we make any changes. We do not want to have an unintended consequence of anything we are doing.

So we have not decided to do anything until we have a chance to sit down, review it with you, review it with stakeholders, make sure that decisions made will be good decisions. So we are not going to do anything until it is a very thoughtful plan, but we do want to get the resources to where the Veterans are homeless.

Mr. BANKS. I appreciate that very much. I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

I now recognize Vice-Chair of the Committee Mr. Bilirakis for five minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it. Thank you, Mr. Secretary, for being here and testifying. I have a few questions. The VA's fiscal year 2019 budget request is $8.6 billion for Veterans, for mental health services.

Part of this funding counts for critical one year period following uniform service and transition to civilian life. My colleagues and I on the Committee have had multiple hearings and roundtables, one just the other day, on the transition assistance process. Can you specifically tell me what the Department is doing to assist in this transition in the upcoming year?

Mr. SHULKIN. Yeah. First thing that we are doing, we have taken a look at this TAPS program, this transition program, and recognize that we could be doing it a lot better. This is a shared responsibility with the Department of Defense.

Our Veterans' experience office has really looked at this and made a number of recommendations that we are working through with the Department of Defense to make that a better program. And I think changes already have taken place that have made it a better program.

We need to pre-enroll our Veterans in their benefits so that they know they have them when they leave instead of wondering and going through a lengthy process after they leave, wondering how they get access to benefits. That is our biggest issue, to make sure people know these services are there for them, make it easy for them, essentially an auto-enrollment process so that there is no work to be done.

Mr. BILIRAKIS. Okay. Thank you. Next question has to do with the Blue Water Navy Veterans. The VA budget seeks $2.9 billion for Veterans' benefits including disability compensation benefits, programs for 4.5 million Veterans, and 600,000 survivors. As you know, certain Veterans such as the Blue Water Navy Veterans are excluded from these benefits. While you have said in the past that these Veterans should not be waiting any longer, that is a quote,

I want to know if the VA has any plans to reexamine this in the upcoming year. If not, why not?

Mr. SHULKIN. Congressman, the problem is, there is not much to reexamine. There is not data there that we can go back. I have tried every which way to see if we could find ships, and do microscopic analyses, or do new studies. There is not going to be new studies. This is about our obligation to those who have served. And to simply keep on passing the buck on this and not honoring this country's obligation to our Veterans I do not think is morally the right thing to do.

So I am committed to working with you, and I know the Chairman feels the same way, to try to find a way to honor our obligation to these Veterans. And we are working now to have discussions with the Administration to work with Congress. We need to find those offsets, we need to find a way to do this. So I believe it is morally and ethically the right thing to do because there is not going to be scientific data, unfortunately, 40, 50 years later to be able to rely upon.

Mr. BILIRAKIS. So you would consider this as a top priority?

Mr. SHULKIN. I think we have to do this, and I think we have to find the offsets to be able to go ahead and to resolve this issue. They have waited too long.

Mr. BILIRAKIS. Yeah. The Chairman has found the offsets and I know he wants to proceed—

Mr. SHULKIN. Good.

Mr. BILIRAKIS [continued]. —so hopefully we can get this done—

Mr. SHULKIN. Yes.

Mr. BILIRAKIS [continued]. —very soon.

Mr. SHULKIN. Thank you.

Mr. BILIRAKIS. Like you said, they can't wait any longer.

Mr. SHULKIN. Thank you.

Mr. BILIRAKIS. Appreciate it. Question three has to do with the burn pits. The fiscal year 2019 VA budget requests $727 million for direct research, a 14 percent increase over the fiscal year 2018 levels. One of my priorities in this Committee is to examine efforts to improve research and treatment for Veterans who may be experiencing negative health effects due to toxic exposure such as burn pit inhalation during their military service. I know it is a priority for a lot of Members here on the Committee, both on the Republican side and the Democrat side. What is the VA doing to further this goal?

Mr. SHULKIN. Yeah. I am trying to see. I do not know the answer to that question. Mark, do you?

Mr. YOW. Can we take it for the record?

Mr. SHULKIN. Can we get back to you on that? I agree with you, we—

Mr. BILIRAKIS. Please do.

Mr. SHULKIN [continued]. —should, yes.

Mr. BILIRAKIS. Thank you. Well, I have got 20 seconds. I guess I will yield them back, Mr. Chairman, and I will submit the rest of the questions. Thank you very much. I appreciate it.

The CHAIRMAN. I thank the gentleman.

Ms. Esty, you are recognized for five minutes.

Ms. ESTY. Thank you, Mr. Chairman. And thank you, Mr. Secretary, and thank you for taking the time to meet with us yesterday. I think it is really important that we keep open lines of communication.

We are here today to talk about we can better deliver care for Veterans and their families. And I know we have a shared goal around that, but we in Congress have a responsibility to make sure that those tax payer funds are wisely spent, and properly spent in service of all of that. And I do appreciate your willingness to speak with us on the IG's report, and we will deal with that at another time.

I do want to associate myself with the remarks of the good gentleman, Bilirakis, burn pits and Blue Water Veterans are very big issues in my district, have legislation on both of those bills, and we are looking forward to passing up. And the one other issue I want to flag is what we discussed at breakfast yesterday, is really rethinking a little bit on the disability/ability issue. What can we do for more temporary disability status in order to able our Veterans to get back and fully participate in the economy? And I think that is something I hope we pursue and figure out a way to do that.

I want to focus with our time here, and I am reserving, Mr. Chairman, 30 seconds for my friend, the gentleman from Minnesota, my former district in Minnesota 1, for 30 seconds at the end. So I will keep track of time here.

I want to turn to the appeals modernization efforts and what we talked about over the last, you know, last several months. Looking at as the appeals modernization is enacted and RAMP expands into new VA regional offices, do you feel that the proposed fiscal year 2019 budget will appropriately handle the continued focus on completing pending legacy appeals? We have a lot of concerns on legacy appeals.

Mr. SHULKIN. Yeah, I do. I think that we are adding 605 FTEs to the appeals process, we are hoping that in fiscal year 2019 we have as much as 25 percent that are going into the RAMP process. The numbers are extraordinary. Of the 680 Veterans that have chosen the RAMP process electively, they have gotten an answer in 38 days versus over a thousand days in the traditional process. So working with our VSOs and working with you in outreach efforts, we hope to make people aware of this as an option because we want them to get these resolved quickly.

Ms. ESTY. We are encouraged by the drive to reduce redundancy of self-reporting income status, because we know this has been an issue on the claw back for pension benefits. As I understand it, income information will be provided by the Social Security Administration, IRS, what systems will be in place to ensure that reporting errors are not taking place in that communication?

Mr. SHULKIN. Jamie, do you know on the reporting errors?

Mr. MANKER. So I will have to get back to you on that—

Ms. ESTY. Okay.

Mr. MANKER [continued]. —with what checks and balances we have in place.

Ms. ESTY. Okay. I would like to turn now to a follow-up on the caregivers hearing from last week. You proposed limiting an expansion of the VA program of comprehensive assistance for family

caregivers to only those who fall into Tier III, the most severally ill or injured Veterans. Can you clarify—because I have to say there was some disagreement within the press and those in the room in understanding what you meant by that limitation—whether your recommendation is to maintain the current eligibility criteria for post-911 Veterans and expand only to pre-911 in Tier III, or if the program post-expansion would be only limited to Veterans in Tier III from then on, whether their service was pre-911 or post-911?

Mr. SHULKIN. Yeah. No. Thank you. First of all, this is, of course, your decision, I am giving you my advice on this in terms of using our resources most effectively. My recommendation would be that everyone who currently has the program should be grandfathered under the current rules. I do not think it is fair to award somebody a support and then change the rules on them after you have started the process.

So for our 27,000 that are currently in the program, I would not recommend changing that. But going forward, if there is a decision to expand eligibility, I believe you should pick a standard that is used by other professional standards today, which would be equivalent to a Tier III; three ADLs plus cognitive dysfunction.

Ms. ESTY. Thank you.

The CHAIRMAN. Okay. The gentlelady—

Ms. ESTY. I yield back, which did not—

The CHAIRMAN. The gentlelady's time has expired. Let's see.

I think, General Bergman, you are up, five minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. And thanks, Dr. Shulkin, and all the rest of you for being here. I know I had to step out to a different event here for a while, and I know that my colleague Dr. Wenstrup asked questions about VA facilities.

In the reinvestment of the dollars that you are getting from closing or shutting down unused space, can you track on a short term basis and then a long term projection as to exactly how you are going to reinvest the dollars that you save from not maintaining a space open that is not being used?

Mr. SHULKIN. Yes. Yes, we will be able to do that. Currently today when we dispose of a property, sometimes very large properties like in Pittsburgh or in New Orleans we disposed of the whole site that we had lost in Katrina, we give that back, not to the VA, we give that back to GSA or the General Treasury. Under the President's infrastructure program that he announced on Monday, in there would be a proposal that VA could retain those proceeds if we were to give back property, and we would track that very specifically and they would be reinvested in infrastructure in the VA.

Mr. BERGMAN. So if we looked at the inventory, if you will, of facilities whether they are not being used at all or whether they have just—you know they are phased out because of new building in that particular area, could we do a, if you will, a multiple listing, you know, like you see in real estate that as the VA, here is what we have in our inventory across the country, and here is what is for sale, if you will?

Mr. SHULKIN. Yeah. Yeah. I think that is a great way to do it. We have been handling them individually by local markets, but I think we could put—

Mr. BERGMAN. Well, and the reason I asked the question is because I have been involved for decades in BRAC. I know sometimes people get scared when you use that term, but I have been on both sides of that equation whether it be arguing for the base staying open or arguing for something being repurposed, and we have had some really outstanding examples of how to do it over the course of the last 40 or 50 years. But it takes an informed partnership between those trying to dispose of the facilities and those within a local community, or whoever, who might want to use that. So I look forward to you continuing to developing that and also providing that availability for those of us who want to see how it is going, what does the market look like, if you will, what is the fair market.

Different subject. In your pamphlet here, and we talked a little bit about this yesterday, the addition of full-time equivalents to handle new tasks, bringing people up and online. Is there an alternative, rather than just adding full-time people, and specific to the appeals process? We know that there is probably a RAMP where you have a peak, and then if we do it right, it is going to drop off. You know, that is just the way it is.

Mr. SHULKIN. Yeah.

Mr. BERGMAN. Do we really need to add the full-time equivalents to the point where will they be up to speed in what they are doing in time for that peak, or, you know, have we got things synced up?

Mr. MANKER. Yes, sir. So we are taking multi-pronged approach to getting our FTE up and available for processing claims when the law is fully enacted. What we are doing is we are using a program called WARTAC where we recruit military members as they are transitioning from service to civilian life, and teaching them to be claims processors and appeals processors.

Mr. BERGMAN. So what do we do after the peak has passed? What is their job after the peak? Because we have an X-number of Veterans—

Mr. MANKER. Yes, sir.

Mr. BERGMAN [continued]. —that are going to be applying, and there is going to be a spike.

Mr. MANKER. Sure.

Mr. BERGMAN. What do we do with that full-time equivalent after that peak has passed and now—

Mr. MANKER. That is a great question, and how I would respond to that is, we experience about 55 FTE per pay period in attrition, so I think natural attrition will take care of the issue of the additional FTE that we have in the books.

Mr. BERGMAN. Okay. Well, thank you. We, as a Committee, there are no easy decisions here. You know that, we know that. And the point is as a Committee to work together with all of you, we hold each other accountable up here, we know that you do the same, the question that we all have is how do we do that together? And I yield back, sir.

The CHAIRMAN. I thank the gentleman for yielding.

Ms. Radewagen, you are recognized for five minutes.

Ms. RADEWAGEN. I thank you, Mr. Chairman and Ranking Member, for holding this hearing today. Thank you, Secretary Shulkin, and your team for coming in early to answer our questions. It is always a pleasure to see you. Thank you again for yesterday's meeting, it was very useful.

My home district of American Samoa consistently boasts one of the highest rates of recruitment in the Nation, and, of course, I never get tired of emphasizing this fact, and I am extremely proud of and thankful for our island's Veterans.

Unfortunately, this increased enlistment means a disproportionate amount of our community suffers from PTSD and mental health issues associated with service. I have friends, neighbors, and close relatives who bear these invisible wounds. And while it would be a great dishonor to characterize these brave soldiers as victims, it would be an even greater dishonor to lapse in our obligation to provide them with the care required for their complex and often misunderstood mental health issues.

Mr. Secretary, several different charts and figures have come across my desk, and I hope you can help me interpret some contradicting figures. Could you please clarify whether or not the budget proposal requests more or less funding for medical research compared to the 2018 request? And how much research funding do you hope to dedicate to mental health research?

Mr. SHULKIN. Yeah. Our research request in the 2019 budget is $727 million. That is an increase, a small increase, but it is an increase from the fiscal year 2018. In addition to that, we have about $1.1 billion of external grants. Some of them Government grants, some of them commercial grants. So together it is about a $2 billion budget for research.

Mental health is one our key areas of focus, this is critical. I do not have the exact number. Mark, do you have the number for mental health and research?

Mr. YOW. Not for mental health, sir. But the actual increase to the appropriation goes from $640 million in 2018 to $727 million in 2019.

Mr. SHULKIN. Yeah.

Mr. YOW. So it is an $87 million increase.

Mr. SHULKIN. Yeah.

Mr. YOW. But we can get the number from Mental Health.

Ms. RADEWAGEN. My staff and I have had meetings with companies and groups who are interested in working with VA to do PTSD and mental health research. What role do public or private partnerships play in maximizing VA's use of their budget, especially regarding research and developing mental health care?

Mr. SHULKIN. We need to be doing more of that. There are, you know, the advances in science and technology are absolutely incredible. So you take our $727 million that we are proposing for research and you match it with the $1.1 billion of Federal and commercial grants, and now you have a very substantial amount of research dedicated all to the health of Veterans. But we need to be doing more of that, and we need to be working with the private sector, and reaching out more to see what is out there that could help, particularly with PTSD and mental health issues.

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

The CHAIRMAN. I thank the gentlelady for yielding.

I now yield to Chairman Arrington for five minutes.

Mr. ARRINGTON. Thank you, Mr. Chairman. And,

Mr. Secretary, thank you for being here along with your team. I want to focus on the stewardship aspect of research, with $12 billion additional funds to deliver for our Veterans on behalf of the tax payers. And as somebody who has helped run a government agency, I know the challenges you face, but it is imperative that you are able to manage your assets, and the most important of your assets are your people, for any organization. How many people will this $12 billion translate into, new people?

Mr. SHULKIN. Yeah. I believe that our budget prior to the budget caps deal was an incremental 6,200 people. But it may be more now that there have been additional funds allocated.

Mr. ARRINGTON. Okay. Sixty-two hundred additional—

Mr. SHULKIN. Additional.

Mr. ARRINGTON [continued]. —employees at the VA, and that brings the total number of employees in the VA enterprise to?

Mr. SHULKIN. Like 373,000.

The CHAIRMAN. Is that your biggest budget expense?

Mr. SHULKIN. Sure.

Mr. ARRINGTON. Okay. So we got to get this right.

Mr. SHULKIN. Absolutely.

The CHAIRMAN. And I must say that my initial introduction to the VA was frustrating with respect to managing people for performance and achieving the desired outcomes. Accountability would be at the core of that, and that is a challenge in any organization, but in Government especially. Bureaucracy, civil service roles, unions, I mean, how do you do this?

Well, under the leadership of Chairman Roe, and Ranking Member Walz, and the bipartisan efforts, we gave you the accountability tools, or at least some accountability tools, some new authority and flexibility. How is that going? How are you exercising it? Do you need more?

Mr. SHULKIN. Well, first of all, thank you for giving us that authority. Since we have opened up the Office of Accountability and Whistleblower Protection, 1,300 employees have been removed in the last eight months. We do not have a target or goal for that, it is not our objective to reach that. But our objective to make sure that we are doing the job that we are doing and everybody understands that they serve Veterans is doing that job. And so we are focused on that, it is going to—

Mr. ARRINGTON. Can you tell the difference? Do you feel a shift in the culture with these new tools, set of tools?

Mr. SHULKIN. You know, I think that one of the things that you learn when you run an organization as big as VA, there is a different culture at each VA. And I think that there is a lot of work to do at some VAs that still remains, and there are others that clearly have used this to improve and that is noticeable, but it is not yet noticeable at all of our facilities.

Mr. ARRINGTON. In this same vein, and I am so grateful to work with Ranking Member O'Rourke and our Subcommittee, and I am

delighted that we have been able to achieve a lot of bipartisan work. Probably the most productive Committee in Congress. Thirty-five bills passing the House, twelve have become law. I mean, so I think we have got a great team, including the President, pushing on this. And he is fighting for our Veterans as are my colleagues.

This is the biggest point of frustration for me with respect to managing our people and getting that right. My first hearing we got a report from the GAO that there were hundreds of VA employees who were union members, who spent a hundred percent of their time on union activity; a hundred percent.

Now there could have been more because the tracking was terrible, and we have been asking for data since the 1970s, but the people back in West Texas, and my Veterans, 40,000 in 29 rural counties, they find it outrageous that somebody would spend a hundred percent of their time on something other than the job they were hired to do. Could you please tell me how you feel about that? I have got a bill, what could we do to help you? Is that a challenge in changing the culture and managing your assets? And after this answer, I yield back, Mr. Chairman.

Mr. SHULKIN. Okay. Thank you. I come from the private sector, I have run institutions with very, very large unions, and I have not seen that before. Where the time that is spent on union time is usually supported by the union dues and the union itself. I do believe that our unions are productive partners with us, and I do really appreciate the collaboration that we have because I believe that they care about getting the right services to Veterans.

But I do believe that the time spent, that the Government pays for, its employees should be to serve Veterans in direct Veteran services. This is not an anti-union position, I believe very strongly we need to work with them, but I believe that we should be looking at alternative ways to make sure union activity and direct Veteran care are separated.

The CHAIRMAN. I thank the gentleman for yielding.

Dr. Dunn, you are recognized for five minutes.

Mr. DUNN. Thank you very much, Mr. Chair, and thank you, Mr. Secretary. I am going to change focus a little bit. You have requested a major construction increase of $1.13 billion, the largest element of that is a $400 million seismic correction fund.

Mr. SHULKIN. Yes.

Mr. DUNN. Your suggested appropriations language stipulates that the fund be available regardless of the estimated cost of the project, that is regardless. So what does that mean exactly?

Mr. SHULKIN. Yeah. I think you are right in asking that question. I am not sure what that means. Are you familiar with that? Because $400 million should be $400 million, you do not want to have it go for—

Mr. DUNN. I am reading that and I am thinking slush fund.

Mr. SHULKIN. Yeah.

Mr. RYCHALSKI. Right. I do not think that was the intent. But, frankly, that is a good question, I would have to come back to you with an answer. I do not know what the language means—

Mr. DUNN. Let's visit that again before the final. In the past, the GAO has raised concerns about the VA employees gaming the cap-

ital projects ranking system, or SCIP, by improperly coding projects as seismic corrections. I would like to be assured that these requested seismic fund projects are truly to harden buildings that are in earthquake zones. Can you give me that assurance?

Mr. SHULKIN. Yeah. Yeah. I do know—Mark, are you familiar with the ratings on the SCIP process? I do know when I took a look at this last time I was concerned about the same thing, how highly prioritized the seismic issues were, and I was afraid that if you were not in that part of the country you were not going to get any of our funding.

We did change the prioritization of the seismic, but this is the first time that we have been able to really start substantially dealing with some of these seismic issues that are decades old in deficiencies. But in terms of these projects, I know the specific projects that the $400 million are going for, I do not believe—I believe that they are truly are for seismic improvement.

Mr. DUNN. I actually have, you know, we all have the, you know, the appendix that lists some of these seismic projects in Arkansas, Illinois, South Carolina, not famous—

Mr. SHULKIN. Yeah.

Mr. DUNN [continued]. —earthquake zones. Forty-four states are involved in the shopping list of seismic correction projects, plus D.C. and Puerto Rico. Puerto Rico no doubt needs some rebuilding, I do not think it is seismic, I think it is hurricane related. I would like to be assured that these requested projects and on the wish list, a long wish list, $7.6 billion worth of seismic corrections—Wisconsin and Louisiana are in this list—that, you know, these are truly for seismic projects.

Mr. SHULKIN. Yeah.

Mr. DUNN. I am concerned about that.

Mr. SHULKIN. I think you have raised several good issues about the language in which it said, and also about the criteria. We will, if it is okay, get back to you and sit down with you.

Mr. DUNN. Okay. Let me leave you with a thought. I was reading through the GAO report and it says, "Even though"—this is a quote out of the handouts here—so, "Even though some facility-level planning officials told us they did not think these demolition projects would score high enough to get funding, officials who oversee this SCIP process told us it was possible that if the project's narratives linked backed to priority areas such as seismic corrections that they might get priority that they otherwise would not." So, you know, it is a narrative that causes concern for misleading the oversight Committee.

Mr. SHULKIN. Yeah.

Mr. DUNN. With that, I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

And I would mention on the seismic issues. A little over 200 years ago there was an earthquake in the West Tennessee area along the New Madrid fault where the Mississippi River backed up, that is how some of our lakes were formed there, and church bells rang in Philadelphia from this. So there are needs along the Mississippi River you might not be aware of. One of the largest earthquake faults in the country is there.

And, Mr. Poliquin, I recognize you for five minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman, I appreciate it. Thank you, Mr. Shulkin, for being here, and thank you for your staff to be here. I know, Mr. Shulkin, that the Chairman put this graph up here earlier—

Mr. SHULKIN. Yep.

Mr. POLIQUIN [continued]. —and it is really important, I think, for everyone to see. We are in the business of caring for our Veterans, and if I am not mistaken, I would like you to confirm this, Doctor, when we have the WWII folks and the Korea folks that are now moving on, the population of our Veterans that we are responsible for caring for is dropping, but at the same time I know a lot of our young men and women coming back from the Middle East are gravely injured, and hurt, and need to be cared for, and I understand all this.

But what I am looking at is a budget that has grown dramatically over the last five or ten years—pick the period—greatly outpacing the growth of the total Federal government, greatly outpacing the growth of our economy. And so the point I want to make, why I am holding it up so long, is when you have an economy that is growing at X and a department that is growing at, I do not know, six times X, whatever it is, five times X, is that it is not sustainable.

And I would also like to remind you, Mr. Secretary—and I know you know this because we talked about this yesterday—is that our Federal government is horribly in debt; horribly in debt. Twenty-one trillion dollars to be exact, or almost twenty-one trillion dollars. You know, with interest rates rising and the economy picking up, there is going to be more and more pressure on interest rates. So the debt service requirements, the interest on that debt is just going to continue to go up.

So my question to you is this. You are coming back to us asking for another $12 billion in a budget that has gone up dramatically, continues to go up dramatically, greatly outpacing the growth of the rest of the Federal government and the economy, it is clearly not sustainable. So could you, please, just in a nutshell, tell us, Mr. Shulkin, what are the two or three top drivers that is causing this to happen, and why you have to come back to us every year asking for, in this case, another $12 billion?

Mr. SHULKIN. Yeah. Well, Congressman, I share your exact concern. I think you said this correct, it is why we produced that graph. That we cannot continue to do business as usual, that this will eventually lead to us not being able to support our country's Veterans, which would be a great error and lapse of our responsibility. So we have to do things differently.

We are dealing with problems that have been essentially neglected in the VA for decades; putting in a financial management system that still runs on COBOL programming; running 138 different versions of an electronic health record that is 35 years old that we are putting all of our money just to maintain it; dealing with old hiring practices and not having the right accountability in the past.

So what we are doing is we are doing everything we can, this investment, to change that. To bring us modernized systems, to decrease the rate of increase. And my whole team knows that is our

goal, to bend the cost curve because we cannot have another graph like that for another five or ten years.

So the drivers are Vietnam Veterans age 67 now on average, getting older, requiring more services. You have talked about people that continue to return with significant needs. Our mandatory benefits rising at huge growth rates, our Veterans have earned those benefits but we have to make sure that our benefits are designed to help people return to well-functioning, well-being.

Mr. POLIQUIN. Well, I am glad you mentioned that, Mr. Secretary, because I believe, and correct me if I am mistaken, the goal is when a Veteran comes to us with a malady is to get them better—

Mr. SHULKIN. Yes.

Mr. POLIQUIN [continued]. —and have them become independent and okay. Would you cite for us what we talked about yesterday at breakfast about sleep apnea versus someone that comes in who is an amputee, and go down that path because I think it would be important to get out there?

Mr. SHULKIN. Yeah. Yeah. What we are doing is we started a process six or seven years ago which is to re-look at all of our body systems. We are now in the process of looking at issues like sleep apnea. Sleep apnea has a 50 percent service-connection with it. We are spending billions of dollars on that.

Fortunately, medical advancements have helped us in being able to treat this condition. We need to diagnose it properly, treat it, manage it, and then people can go on with their lives in a normal, healthy, functioning way. And we want people to get that treatment that is our goal at VA to get the right treatment.

But once we get people back and being able to function in the way that they should with adequate treatment, there should be a recognition of that in our benefits program. And so we are going through this process, we work with our VSOs through this process, it has been going on. But we believe a good system like this needs to evolve and change as science changes.

Mr. POLIQUIN. Mr. Chairman, I know my time is up, but please may I have just a few more seconds to ask a question that is imperative to the staff?

The CHAIRMAN. (Indiscernible) just a few more seconds.

Mr. POLIQUIN. Thank you. I know that was lean yes. Mr. Secretary, you requested $25 million this year to reimburse the judgment fund for construction claims and settlements. Will this zero out the VA's liability to the judgment fund?

Mr. SHULKIN. Anybody know? We have to get back to you on that.

Mr. POLIQUIN. I am glad, Mr. Chairman, you gave me the time to ask the question, thank you.

The CHAIRMAN. The gentleman's time has expired.

I will now, having no further Members here, I will yield to Mr. Walz for any closing statements.

Mr. WALZ. I yield one minute to the gentleman from Texas, Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Ranking Member Walz. And very quickly, I had asked you for total outstanding mental health hires, vacancies. Your staff got back to us, said it is 2,912.

Mr. SHULKIN. Yes.

Mr. O'ROURKE. I would also ask for all outstanding primary care hires. They gave us a number that is in the hundreds, so I probably did not ask the question the right way. Apart from mental health, I want to know how many outstanding primary care provider hires there are.

Mr. SHULKIN. Yeah.

Mr. O'ROURKE. Many of us are getting questions at our town halls; my primary care provider is gone, I have not been reassigned, I do not know who to go to. So I want to know what the outstanding number is. Would you get that to me and the Members of the Committee?

Mr. SHULKIN. Yeah. I was handed probably what you were, which says in primary care 270, but it seems small.

Mr. O'ROURKE. It has got to be a lot higher?

Mr. SHULKIN. It has got to be higher, yeah.

The CHAIRMAN. And then last point, I will yield back, Mr. Chairman. I think inadvertently my colleague

Mr. Arrington and the Secretary conflated two distinct terms; official time and union activity.

Mr. ARRINGTON. Correct.

Mr. O'ROURKE. If someone is performing a hundred percent of their job on official time, that is one thing—and we can have a reasonable debate on that and come to different conclusions—that is not union time, and I think you misspoke earlier.

Mr. SHULKIN. Okay.

Mr. O'ROURKE. I would like you to just, for the record, share that you intended to say official time not union time. No one is allowed to spend a hundred percent of their work day on union time.

Mr. SHULKIN. Thank you for clarifying that.

Mr. WALZ. I thank the gentleman, and thank you for being here, Mr. Chairman. And I want to be absolutely clear. What distinguishes this Committee I think from any other, and I it has been noted, is our ability to focus together on the issues that matter. I am glad there was a lot of press here today, I hope they were here for the budget.

Mr. SHULKIN. I am sure.

Mr. WALZ. I think all of us know what that is, and that is a fair thing. And I want to be very clear, no one is not taking those things very seriously. We have had those conversations, I have indicated, it appears like there have been allegations of criminal contact on both sides of these things, those things need to be found out. I am grateful for you in the decision to reimburse the Federal Government and move on.

I would note that the reason this Committee works is because we have chosen collectively here not to allow partisan natures to get in this. Your predecessor sat in that chair and took an awful lot of grilling because he was a Democratic President's nominee that was there. You have the unique position of being someone who spans both of those. So I hope everyone here understands that that is what we are focusing.

And I also would like to do of clarify one thing because this one does get into—I am a little bit miffed by on it. I have sat on this Committee longer than anyone else. I have carried the Blue Water

Navy bill, this has been a passion of me. I was there with the Nehmer claims, I was there with Parkinson's.

My disagreement is not about getting this done, or the commitment of doing this. My disagreement is we should not be asking one group of wounded warriors to pay for another. My suggestions are to ask for a one-tenth of one percent off the tax cuts to the top tax bracket. Or I even suggested, somewhat facetiously but maybe not, that if you got a deferment to Vietnam you could help pay for the ones who were there.

So I want to be very clear. No one disagrees up here, the Chairman's commitment to fixing Blue Water Navy is second to nobody in this country. He is doing Yeoman's work of trying to find these things. And by presenting that, I do not take offense to that. I simply disagree with how we are doing it, he brings up a valid point.

I hope from the perspective of where you are at, we are all committed to getting this right, we are trying to find it. I understand the commitment to use the COLA round down. I think there is valid arguments on that, but they are not coming from a position that we do not care about getting it done. So I just want to make clear on that.

Mr. SHULKIN. Thank you.

Mr. WALZ. I would note that the accountability act. Again, 30 percent of the people removed come from food service and laundry. Just as a thought of where we are going. Perhaps training on that end.

Mr. SHULKIN. Yeah.

Mr. WALZ. Perhaps new employees that are there. Perhaps we are quick to move people before we get them in. I believe strongly in accountability because I was there to help graph this. But my intention was not to get rid of housekeepers if these are things that can be corrected with training, and HR, and management, if you will.

I thank the gentleman for clarifying the position on official time. Really important clarification. We get that wrong, there is a lot of—I understand some tensions around this, but now we are back to the work of a budget.

Again, I am grateful. The President sent down a budget, the Constitution is very clear on this, that we appreciate his suggestion. Congress' job is to write the budgets. Congress' job is to find that out with the input from trusted and folks who have to deliver that.

I think there is a lot of commonality in getting there. I think the issue on budget growth, we do need to have that conversation, though, because, once again, I do not disagree. Management practices, all of that. We do have to acknowledge, though, I would argue the VA, especially the clinical folks, are doing such a fantastic job, we have added 2.5 million Veterans who come to the VA and want to get their care there. That is it. Vietnam Veterans are going through the, you know, the rabbit through the python thing, that we have them there, there are other things at work.

And I would close with this. If you go to war there is a cost that does not end with the last bullet. And we have been at war for 16 years, we have asked people to go, we are going to have to budget for that. And, yes, it has to, if it does not become sustainable, but this is one that I do not see that this is an option or a discretional

funding, this is an absolute mandatory requirement to care for our Veterans and we are going to have to budget accordingly.

So, again, I thank the Chairman for his leadership. I thank you, Mr. Secretary, for being here in the midst of a lot of chaos and focusing on Veterans. And I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

And I thank the panel for being here today and starting the discussion of the 2019 budget. And, you know, I was sitting here thinking, as we close, about—for our folks that are watching this—just what are the services that VA actually provides?

And I have been here now nine going on ten years, and basically it provides quality health care for over 9 million Veterans. And whether it is inside the VA or outside the VA. Their commitment is to provide quality care wherever the Veteran gets that care.

It provides memorial benefits—we talked about that earlier—to over 140,000 Veterans a year who have now passed and those benefits to them and their families. Pension benefits. Hundreds of thousands of Veterans get pension benefits. Group life insurance, we do not think about that, at 6 million.

Home loans. Veterans, now I think over 3 million get a home loan from the VA. Compensation benefits over, what, 4 to 5 million of our Veterans get the—a huge benefit, the educational benefits. Both the Montgomery GI bill, the post-9/11, and now the Forever GI bill. That Veterans are able now, and half, I think, of the young men and women who separate from the military use that GI bill benefit. One is sitting in this chair who used that GI bill benefit.

And I want to thank the President for his focus on the VA. I remember sitting up at night and late in the evening when he gave his acceptance speech, and one of the first things out his mouth was his commitment to the Nation's Veterans. And I very much appreciate that, and I do not think it stopped. Every time he talks about—gives a speech, he mentions our Nation's heroes. And I thank him for that.

We have a huge—this Committee, in a bipartisan way, as the Ranking Member mentioned, has got a huge amount of work to do this year. We have transition of the Choice program, we have got to get that done so you can move on with that. We have got the asset review to get the VA right-sized, to begin to go down a pathway of more efficient care in the neighborhoods, in the communities where our Veterans live.

We have got EHR modernization that is starting. We have got appeals reform that we are just now—we have talked about that just a little this morning. As Mr. Walz brought up, one of my passions that I want to get off the table is our Blue Water Navy friends. I want to get that solved.

We have got caregivers, we are moving forward with that. By the 7th of March we have our first roundtable on that. Estate VeteransState veterans homes were mentioned. I think those are tremendous. Everywhere I have been I looked estate Veteran at state veteran homes. Those are really quality places our older Veterans can go.

You mentioned as your number one health priority, suicide prevention. We have got enormous work to do on that, and there is

a huge investment in this budget for reducing the amount of suicide we have in this country.

And, lastly, I know we always—a privatization comes up, it is hard to do that with a straight face. In the nine years I have been here, there were 250,000 employees at the VA when I started on this Committee, 2009. I think you just said there are now 373,000, and the budget has gone from $93 billion to $198 billion. That does not look like privatizing to me that looks like a commitment that this Nation is making to its Veterans. And I am proud of that.

I think this is something—when I go home, and I live in a very conservative area of the country, I will never apologize for money we spend on our Nation's Veterans, never. So I think, and I do not think a person on this dais does, I think we can go home proudly and say that we have supported—and this entire Congress, both Republicans and Democrats have done this.

Just lastly as we close, we have a number of questions for the record, and one of those I want to get out before is, is transition to Choice. And you do not have to answer it right now. But we have money that will last until the end of May, and then further money was appropriated

Mr. SHULKIN. Yes.

The CHAIRMAN. —and then that is until the end of the fiscal year which is 1 October, 30 September. Then how do we get from 30 September to March of 2019 because that appears to be when we are going to have this—you will have the time, your team will have the time to get this fully—this new Choice program fully implemented? You do not have to answer that right now but I need that. And will it be under the budget caps?

With that being said, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered. Hearing is adjourned.

[The Independent Budget of Disabled American Veterans, Paralyzed Veterans of America, Veterans of Foreign Wars of the United States appears on p.]

[Whereupon, at 10:07 a.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable David J. Shulkin, M.D.

Good morning Chairman Roe, Ranking Member Walz, and distinguished members of the Committee. Thank you for the opportunity to testify today in support of the President's Fiscal Year (FY) 2019 Budget, including the FY 2020 Advance Appropriation (AA) request. I am accompanied today by Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer; Mark Yow, Chief Financial Officer for the Veterans Health Administration (VHA); James Manker, Acting Principal Deputy Under Secretary for Benefits; Matthew Sullivan, Deputy Under Secretary for Finance and Planning for the National Cemetery Administration (NCA), and Richard Chandler, Deputy Assistant Secretary for Resource Management, Office of Information and Technology. I also want to thank Congress for making 2017 a legislative success for Veterans. With the unwavering support and leadership of our VA Committees, Congress supported and passed groundbreaking legislation on Department of Veterans Affairs (VA) accountability, appeals reform, the Forever GI Bill, Veterans Choice improvements, personnel improvements, and extended Choice funding twice. We have important work left to do, but I am confident we are moving in the right direction. The 2019 budget request fulfills the President's strong commitment to all of our Nation's Veterans by providing the resources necessary to improve the care and support our Veterans have earned through sacrifice and service to our country.

Fiscal Year (FY) 2019 Budget Request

The President's FY 2019 Budget requests $198.6 billion for VA - $88.9 billion in discretionary funding (including medical care collections), of which $76.5 billion is requested as the FY 2019 AA for Medical Care including collections. The $76.5 billion is comprised of $74.1 billion previously requested (including collections), and an annual appropriation adjustment of $500 million for Medical Services for community care and $1.9 billion for the Veterans Choice Fund. In total, the discretionary request is an increase of $6.8 billion, or 8.3 percent, over the President's FY 2018 Budget request. It will sustain the progress we have made and provide additional resources to improve patient access and timeliness of medical care services for the approximately 9 million enrolled Veterans eligible for VA health care, while improving benefits delivery for our Veterans and their beneficiaries. The President's FY 2019 budget also requests $109.7 billion in mandatory funding, of which $107.7 billion was previously requested, for programs such as disability compensation and pensions.

For the FY 2020 AA, the budget requests $79.1 billion in discretionary funding including collections for Medical Care and $121.3 billion in mandatory advance appropriations for Compensation and Pensions, Readjustment Benefits, and Veterans Insurance and Indemnities benefits programs in the Veterans Benefits Administration (VBA).

This is a strong budget request that fulfills the President's commitment to Veterans by ensuring the Nation's Veterans receive high-quality health care and timely access to benefits and services while concurrently improving efficiency and fiscal responsibility. I urge Congress to support and fully fund our FY 2019 and FY 2020 AA budget requests - these resources are critical to enabling the Department to meet the increasing needs of our Veterans and successfully execute my top five priorities: 1) Focus Resources; 2) Modernize VA Systems and Services; 3) Improve Timeliness; 4) Suicide Prevention; and 5) Provide Greater Choice.

I want to emphasize that the FY 2019 Budget is not a "business as usual" VA Budget. We have critically assessed and prioritized our needs and aggressively pursued internal offsets, modernization reforms, and other efficiencies to provide Veterans the quality care they have earned while serving as a responsible fiscal steward. I greatly appreciate Congress' ongoing support for VA, as demonstrated by con-

sistent support for our legislative priorities and consistently generous enacted appropriations. On behalf of the entire VA and the many Veterans we serve, I thank you for your unflagging commitment to our mission. I take very seriously my obligation to you, the American taxpayer and the Veterans who served our country so well. That commitment is represented in this budget request in which I have worked to bend the cost curve through targeted spending and significant reforms in an attempt to ensure that the VA remains sustainable for years to come.

Priority 1: Focus Resources

The FY 2019 Budget includes $ 76.5 billion for Medical Care, including collections, $4.2 billion above the FY 2018 Budget and $79.1 billion for the FY 2020 AA. I am committed to ensuring Veterans get high quality, timely and convenient access to care that is affordable for future generations. As a result, I am implementing reforms that will prioritize our foundational services while redirecting to the private sector those services that they can do more effectively and efficiently. These foundational services are those that are most related to service-connected disabilities and unique to the skills and mission of VHA.

Foundational Services include these mission-driven services, such as:

- Primary Care, including Women's Health;
- Urgent Care;
- Mental Health Care;
- Geriatrics and Extended Care;
- Rehabilitation (e.g., Spinal cord, brain injury/polytrauma, prosthesis/orthoses, blind rehab);
- Post Deployment Health Care; and
- War-Related Illness and Injury Study Centers functions.

VA facility and Veterans Integrated Service Network (VISN) leaders are being asked to assess additional, community options for other health services that are important to Veterans, yet may be as effectively or more conveniently delivered by community providers. Local VA leaders have been advised to consider accessibility of VA facilities and convenience factors (like weekend hours), as they develop recommendations for access to community providers for Veterans in their service areas. Let me be clear, however, that this is not the onset of privatizing VA.

While the focus on foundational services will be a significant change to the way VA provides health care, VA will continue to ensure that the full array of statutory VA health care services are made available to all enrolled Veterans. VA will also continue to offer services that are essential components of Veteran care and assistance, such as assistance for homeless Veterans, Veterans Resource Centers, the Veterans Crisis Line/Suicide Prevention, Mental Health Intensive Case Management, treatment for Military Sexual Trauma, and substance abuse programs.

Investing in foundational services within the Department is not limited to health care. For over a decade, NCA has achieved the highest customer satisfaction rating of any organization-public or private-in the country. They achieved this designation through the American Customer Satisfaction Index six consecutive times. The President's FY 2019 Budget enables the continuation of this unprecedented success with a request for $315.8 million for NCA in FY 2019, an increase of $9.6 million (3 percent) over the FY 2018 request. This request will support the 1,941 Full-Time Equivalent (FTE) employees needed to meet NCA's increasing workload and expansion of services. In FY 2019, NCA will inter over 134,000 Veterans and eligible family members and care for over 3.8 million gravesites. NCA will continue to memorialize Veterans by providing 364,850 headstones and markers, distributing 677,500 Presidential Memorial Certificates, and expanding the Veterans Legacy program to communities across the country. VA is committed to investing in NCA infrastructure, particularly to keep existing national cemeteries open and to construct new cemeteries consistent with burial policies approved by Congress. In addition to NCA's funding, the FY 2019 request includes $117.2 million in major construction funds for three gravesite expansion projects. Upon completion of these expansion projects, and the opening of new cemeteries, nearly 95 percent of the total Veteran -about 20 million Veterans-will have access to a burial option in a national or grant-funded state Veterans' cemetery within 75 miles of their home.

In order to provide Veterans and taxpayers the greatest value for each dollar, the Budget also proposes certain changes to the way in which we spend those resources. For example, our FY 2019 request proposes to merge the Medical Community Care appropriation with the Medical Services appropriation, as was the practice prior to FY 2017. The separate appropriation for Community Care has restricted our Medical Center Directors as they manage their budgets and make decisions about

whether the care can be provided in their facility or must be purchased from community providers. This is a dynamic situation, as our staff must adjust to hiring and departures, emergencies such as the recent hurricanes, and other unanticipated changes in the health care environment throughout the year. This change will maximize our ability to focus even more resources on the services Veterans most need.

To further ensure that our entire budget request is focused serving Veterans, VA has implemented an initiative to detect and prevent fraud, waste, and abuse (STOP FWA). In support of this initiative, VA (1) established the VA Prevention of Fraud, Waste, and Abuse Advisory Committee, which will provide VA insight into best practices utilized in the private and public sector; (2) is partnering with Centers for Medicare & Medicaid Services (CMS) to replicate their investigation process and utilize their data to identify medical providers with performance issues; and (3) is working with the Department of the Treasury to perform a deep dive to move VA's Community Care Program closer to the industry best practices.

In 2019, VA will take steps to achieve mandatory savings of approximately $30 billion over the next 10 years, beginning in FY 2021. Due to advancements in treatment and medical technologies, there has been a decrease in the impacts of certain disabilities on the lives of many Veterans.

Priority 2: Modernizing VA Systems and Services

Focusing resources will only take us so far - we need to modernize our VA systems and services, so the Department can continue to provide high quality, efficient care and services, and keep up with the latest technology and standards of care. Key modernization reform proposals included in the FY 2019 Budget Request are Electronic Health Record Modernization (EHRM), Financial Management Business Transformation, modernizing our legacy systems, and infrastructure improvements.

Electronic Health Record Modernization

The Budget invests $1.2 billion in EHRM. The health and safety of our Veterans is one of our highest national priorities. On June 5, 2017, I announced my decision to adopt the same electronic health record (EHR) system as the Department of Defense (DoD). This transformation is about improving VA services and significantly enhancing the coordination of care for Veterans who receive medical care not only from VA, but DoD and our community partners. We have a tremendous opportunity for the future with EHRM to build transparency with Veterans and their care providers, expand the use of data, and increase our ability to communicate and collaborate with DoD and community care providers. In addition to improving patient care, a single, seamless EHR system will result in a more efficient use of VA resources, particularly as it relates to health care providers. Given the magnitude of this transformation and the significant long-term costs and complex contracting needs, we are requesting a single separate account for this effort.

This new EHR system will enable VA to keep pace with the improvements in health information technology and cyber security which the current system, VistA, is unable to do. Moreover, the acquisition of the same solution as DoD, along with the added support of joint interagency governance and support from national EHR leadership including VA partners in industry, government, academic affiliates, and integrated health care organizations, will enable VA to meaningfully advance the goal of providing a single longitudinal patient record that will capture all of a Servicemember's active duty and Veteran health care experiences. It will enable seamless care between the Departments without the current manual and electronic exchange and reconciliation of data between two separate systems. To that end, I have insisted on high levels of interoperability and data accessibility with our commercial health partners in addition to the interoperability with DoD. Collectively, this will result in better service to our Veterans because transitioning Servicemembers will have their medical records at VA. VA is committed to providing the best possible care to Veterans, while also remaining committed to supporting Veterans' choices to seek care from private providers via our continued investment in the Community Care program.

Legacy Systems Modernization

The FY 2019 Budget continues VA's investment in technology to improve the lives of Veterans. The planned Information Technology (IT) investments prioritize the development of replacements for specific mission critical legacy systems, as well as operations and maintenance of all VA IT infrastructure essential to deliver medical care and benefits to Veterans. The request includes $381 million for development to replace specific mission critical legacy systems, such as the Benefits Delivery Network and the Burial Operations Support System. Investments in IT will also support efforts and initiatives that are directly Veteran-facing, such as mental health

applications to support suicide prevention, modifications of multiple programs to accommodate special requirements of the community care program, Veteran self-service applications (Navigator concept), education claims processing integration consolidation, and benefit claim appeals modernization. The Budget also invests $398 million for information security to protect Veterans' information.

The FY 2019 Budget request would increase the Department's ability to apply agile program management to the dynamics of modern IT development requirements. To do this, the Department proposes increasing the transfer threshold from $1 million to $3 million between development project lines, which equates to less than 1 percent of the Development account. Through the Certification process, Congress will maintain visibility of proposed changes.

Financial Management Business Transformation

Another critical system that will touch the delivery of all health and benefits is our new financial management system, which is under development. The FY 2019 budget requests $72.8 million in IT funds and $48.8 million in fair share reimbursable funding from the Administrations for business process re-engineering to support Financial Management Business Transformation across the Department. These resources support the continued modernization of our financial management system by transforming the Department from numerous stovepipe legacy systems to a proven, flexible, shared service business transaction environment. Even though the U.S. Department of Agriculture (USDA) is not moving forward as VA's Federal Shared Service Provider, VA continues to work with USDA to ensure a smooth transition. VA's Office of Finance continues to manage the program and the implementation is on schedule and within budget.

Infrastructure Improvements and Streamlining

In FY 2019, VA will focus on improving its infrastructure while we transform our health care system to an integrated network to serve Veterans. This budget requests $1.1 billion in Major Construction funding, as well as $706.9 million in Minor Construction for priority infrastructure projects. This funding supports projects including the St. Louis, Missouri, Jefferson Barracks Medical Facility Improvements and Cemetery Expansion project; the Canandaigua, New York, Construction and Renovation project; the Dallas, Texas, Spinal Cord Injury project; and national cemetery expansions in Rittman, Ohio; Mims, Florida; and Holly, Michigan. VA is also requesting $964 million to fund more than 2,100 medical leases in FY 2019 and $672.1 million for activation of new medical facilities.

VA appreciates the support of Congress and is grateful for the passage of the VA Choice and Quality Employment Act of 2017 (Public Law (P.L.), 115–46), which included authorization for 28 major medical leases, some of which had been pending authorization for approximately 3 years. The leases will establish new points of care, expand sites of care, replace expiring leases, and expand VA's research capabilities. In FY 2019, VA is seeking Congressional authorization of four new outpatient clinic leases to expand services currently offered at existing clinics. The requested leases would be located in the vicinities of Lawrence, Indiana; Plano, Texas; Baton Rouge, Louisiana; and Beaumont, Texas.

The FY 2019 Budget includes a new initiative to address VA's highest priority facilities in need of seismic repairs and upgrades. VA's major construction request includes $400 million that will be dedicated to correct critical seismic issues that currently threaten the safety of Veterans and VA staff at VA facilities. The seismic program would fund newly identified unfunded, existing, and partially-funded seismic projects within VA's major, minor, and non-recurring maintenance programs.

VA's FY 2019 Budget includes proposed legislative requests, consistent with the Veteran Coordinated Access & Rewarding Experiences Act draft bill that VA submitted last fall, which, if enacted, would increase the Department's flexibility to meet its capital needs. These proposals include: 1) increasing from $10 million to $20 million the dollar threshold for minor construction projects; 2) modifying title 38 to eliminate statutory impediments to joint facility projects with DoD and other Federal agencies; and 3) expanding VA's enhanced use lease authority to give VA more opportunities to engage the private sector and local governments to repurpose underutilized VA property.

To maximize resources for Veterans, VA repurposed or disposed of 131 of 430 vacant or mostly vacant buildings since June 2017. VA is on track to meet the goal that I set in June 2017 for VA to initiate disposal or reuse actions for all 430 buildings by June 2019.

The Department is also a participant in the White House Infrastructure Initiative, which is exploring additional ways to modernize VA's real property assets, and support our continued delivery of quality care and services to our Nation's Veterans.

The proposed Infrastructure Initiative includes flexibilities for VA to leverage existing assets to continue its efforts to reduce the number of vacant buildings in its inventory; tools to leverage VA assets for the construction of needed new facilities to serve Veterans; and an increase to VA's existing medical facility leasing threshold, which would streamline our leasing process so VA can more quickly and efficiently deliver facilities to provide care and services to Veterans.

Accountability and Effective Management Practices

Another critical system VA is significantly improving relates to employee accountability. The vast majority of employees are dedicated to providing Veterans the care they have earned and deserve. It is unfortunate that some employees have tarnished the reputation of VA while so many have dedicated their lives to serving our Nation's Veterans. We will not tolerate employees who deviate from VA's I–CARE (Integrity, Commitment, Advocacy, Respect, and Excellence) values and underlying responsibility to provide the best level of care and services to them. Last May, VA established the Office of Accountability and Whistleblower Protection. Between June 1, 2017, and December 31, 2017, VA removed more than 900 staff (not including probationary terminations) and placed more than 250 staff on suspensions of 14 days or greater. We thank Congress for passing the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (P.L. 115–41), so that new accountability rules for VA are now the law of the land.

We are also focused on improving our unduly burdensome internal hiring practices. In the face of a national shortage of health care providers, VHA faces competition with the commercial sector for scarce resources. Over the past year, we reduced the time it took to hire Medical Center Directors by 40 percent and obtained approval from the Office of Personnel Management for critical position pay authority for many of our senior health care leaders. But there is much work left to do. I will need Congress' help with legislation to reform recruitment and compensation practices allowing VA to stay competitive with the private sector and other employers.

Priority 3: Improve Timeliness

Access to Care and Wait Times

VA is committed to delivering timely and high quality health care to our Nation's Veterans. Veterans now have access to same-day services for primary care and mental health care at the more than 1,000 all VA clinics across our system. I am also committed to ensuring that any Veteran who requires urgent care will receive timely care.

In 2017, 81.5 percent of nearly 6 million outpatient appointments for new patients were completed within 30 days of the day the Veteran first requested the appointment ("create date"), whereas 97.3 percent of nearly 50.2 million established appointments were completed within 30 days of the date requested by the patient ("patient-indicated date"). VHA has reduced the Electronic Wait List from 56,271 entries to 20,829 entries, a 63.0 percent reduction between June 2014 and December 2017. The Electronic Wait List reflects the total number of all patients for whom appointments cannot be scheduled in 90 days or less. During FY 2018 and FY 2019, VA will continue to focus its efforts to reduce wait times for new patient appointments, with a particular emphasis on primary care, mental health, and medical and surgical specialties.

In FY 2019, VA will expand Veteran access to medical care by increasing medical and clinical staff, improving its facilities, and expanding care provided in the community. The FY 2019 Budget requests a total of $76.5 billion in funding for Veterans' medical care in discretionary budget authority, including collections. The FY 2019 request will support nearly 315,688 medical care FTE, an increase of over 5,792 above the 2018 level.

VA is implementing a VISN-level Gap Coverage plan that will enable facilities to request gap coverage providers in areas that are struggling with staffing shortages. It is a seamless electronic request that allows VISNs to focus resources where they are most needed according to supply and demand. Telehealth will be the principal form of coverage in this initiative, which is budget neutral.

NCA has begun phase one expansion of the weekend burial pilot program, which provides Veterans and family members with increased access to burials at select national cemeteries. During phase one, NCA will offer cremation-only weekend burials at six cemeteries. The FY 2019 Budget will support phase two of the pilot by expanding the weekend program to an additional five cemeteries.

Accelerating Processing of Disability Claims

Since 2013, VA has made remarkable progress toward reducing the backlog of disability compensation claims pending over 125 days. VBA's FY 2019 budget request of $2.9 billion would allow VBA to maintain the improvements made in claims processing over the past several years. This budget prioritizes more timely review of 1.3 million rating claims and 187,000 higher level reviews to decrease the amount of time Veterans wait for a resolution. It also prioritizes fiduciary care for vulnerable beneficiaries to ensure protection for VA's most vulnerable veterans who are unable to manage their VA benefits. This budget supports the disability compensation benefits program for 4.5 million Veterans and 600,000 survivors.

To continue improving disability compensation claims processing, VBA has implemented an initiative called Decision Ready Claims (DRC). The DRC initiative offers Veterans, Servicemembers, and survivors faster supplemental claims decisions through a partnership with Veterans Service Organizations (VSO) and other accredited representatives to assist applicants with ensuring all supporting evidence is included with the claim at the time of submission, enabling the claim to be decided within 30 days of submission to VA. In FY 2019, VBA plans to complete 25 percent, or nearly 300,000 disability compensation claims, under the more timely DRC initiative.

Decisions on Appeals

In August 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act of 2017 (P.L. 115–55), which represents the most significant statutory change to affect VA claims and appeals in decades and provides much-needed reform. VA is in the process of implementing the new claims and appeals system by promulgating regulations, establishing procedures, hiring and training personnel, and developing IT systems. By February 2019, all requests for review of VA decisions will be processed under the new law, which will provide a more efficient claims and appeals process for Veterans, with opportunities for early resolution of disagreements with VA decisions.

The FY 2019 request of $174.8 million for the Board of Veterans' Appeals (the Board) is $19.2 million above the FY 2018 Budget and will sustain the 1,025 FTE who will adjudicate and process legacy appeals while implementing the Appeals Improvement and Modernization Act. The Board is currently on pace to produce over 81,000 decisions, a historic level of production.

In addition, VBA is also undertaking a similar, multi-pronged approach to modernize its appeals process through legislative reform, increased resources, technology, process improvements, and increased efficiencies. The requested $74 million for appeals processing increases VBA's appeals FTEs by 605, more than 40 percent above 2018.

This increase comes after VBA realigned its administrative appeals program under the Appeals Management Office (AMO) in January 2017, as part of an effort to streamline and improve performance in legacy appeals processing. The improved focus and accountability resulting from this realignment helped increase VBA appeals production by 24 percent, decrease its appeals inventory by 10 percent, and increase its appeals resolutions by 10 percent, resolving over 124,000 appeals during FY 2017.

In FY 2019, the Appeals Modernization project will achieve the benefit of using Caseflow Certification, which is a commercially developed system that will help reduce errors and delays caused by disjointed manual processing, and improve the Veteran experience by enabling transparency of appeals processing and ultimately facilitating the delivery of more timely appeals decisions.

Priority 4: Suicide Prevention

Suicide prevention is VA's highest clinical priority, and Veteran suicide is a national health crisis. On average, 20 Veterans die by suicide every day -this is unacceptable. The integration of Mental Health program offices and their alignment with the suicide prevention team and the Veterans Crisis Line is being implemented to further enhance VA's ability to effectively meet the needs of the most vulnerable Veterans. The FY 2019 Budget Request increases resources to standardize suicide screening and risk assessments and expands options for safe and effective treatment for Veterans struggling with post-traumatic stress disorder and suicide.

The FY 2019 Budget requests $8.6 billion for Veterans' mental health services, an increase of 5.8 percent above the 2018 current estimate. It also includes $190 million for suicide prevention outreach. VA recognizes that Veterans are at an increased risk for suicide, and we have implemented a national suicide prevention strategy to address this crisis. VA is bringing the best minds in the public and private sectors together to determine the next steps in implementing the Ending Veteran Suicide Initiative. VA's suicide prevention program is based on a public health

approach that is ongoing, utilizing universal, selective, indicated strategies while recognizing that suicide prevention requires ready access to high-quality mental health services, supplemented by programs that address the risk for suicide directly, starting far earlier in the trajectory that leads to a Veteran taking his or her own life. VA cannot do this alone; 70 percent of Veterans who die by suicide are not actively engaged in VA health care. Veteran suicide is a national issue and can only be ended through a nationwide community-level approach that begins to solve the upstream risks Veterans face, such as loss of belonging, meaningful employment, and engagement with family, friends, and community.

Executive Order to Improve Mental Health Resources

On January 9, 2018, President Trump signed an Executive Order (13822) titled, "Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life." This Executive Order directs DoD, VA, and the Department of Homeland Security to develop a Joint Action Plan that describes concrete actions to provide access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following their discharge, separation, or retirement.

VA encourages all transitioning Servicemembers and Veterans to contact their local VA medical facility or Vet Center to learn about what VHA mental health care services may be available.

REACH VET Initiative

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) program. This program finishes its first year of full implementation in February 2018 and has identified more than 30,000 at risk Veterans to date. REACH VET uses a new predictive model 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, so that VHA providers can review and enhance care and talk to these Veterans about their needs. REACH VET was expanded to provide risk information about suicide and opioids, as well as clinical decision support to Veterans Crisis Line responders and is being further expanded to provide this important risk information to frontline VHA providers. REACH VET is limited to Veterans engaged in our health care system and is risk-focused, so while it is critically important to those Veterans it touches, it is not enough to bring down Veteran suicide rates. We will continue to take bold action aimed at ending all Veteran suicide, not just for those engaged with our system.

Other than Honorable Initiative

We know that 14 of the 20 Veterans who, on average, died by suicide each day in 2014 did not, for various reasons, receive care within VA in 2013 or 2014. Our goal is to more effectively promote and provide care and assistance to such individuals to the maximum extent authorized by law. To that end, beginning on July 5, 2017, VA promoted access to care for emergent mental health care to the more than 500,000 former Servicemembers who separated from active duty with other than honorable (OTH) administrative discharges. This initiative specifically focuses on providing access to former Servicemembers with OTH administrative discharges who are in mental health distress and may be at risk for suicide or other adverse behaviors. As part of this initiative, former Servicemembers with OTH administrative discharges who present to VA seeking emergency mental health care for a condition related to military service would be eligible for evaluation and treatment for their mental health condition. Such individuals may access the VA system for emergency mental health services by visiting a VA emergency room, outpatient clinic, Vet Center, or by calling the Veterans Crisis Line. Services may include assessment, medication management/pharmacotherapy, lab work, case management, psycho-education, and psychotherapy. As of December 30, 2017, VHA had received 3,241 requests for health care services under this program. In addition, in FY 2017, Readjustment Counseling Services through Vet Centers provided services to 1,130 Veterans with "Other than Honorable" administrative discharges and provided 9,889 readjustment counseling visits.

Priority 5: Greater Choice for Veterans

Veterans deserve greater access, choice, and control over their health care. VA is committed to ensuring Veterans can make decisions that work best for themselves and their families. Our current system of providing care for Veterans outside of VA requires that Veterans and community providers navigate a complex and confusing

bureaucracy. VA is committed to building an improved, integrated network for Veterans, community providers, and VA employees; we call these reforms Veteran Coordinated Access & Rewarding Experiences, or Veteran CARE. VA submitted the Veteran CARE legislative proposal package to Congress last fall. The Administration submitted $4 billion in mandatory offsets to fully support the transition from the Veterans Choice Program to the consolidated CARE program through FY 2018 and into FY 2019.

Veteran CARE would clarify and simplify eligibility requirements, build a high performing network, streamline clinical and administrative processes, and implement new care coordination support for Veterans. Veteran CARE would improve Veterans' experience and access to health care, building on the best features of existing community care programs. This new program would complement and support VA's internal capacity for the direct delivery of care with an emphasis on foundations services. The CARE reforms would provide VA with new tools to compete with the private sector on quality and accessibility.

Demand for community care remains high. The Veterans Choice Program comprised approximately 62 percent of all VA community care completed appointments in FY 2017. We thank Congress for the combined $4.2 billion provided in Calendar Year 2017 to continue the Choice Program while discussions continue regarding the future of VA community care. Based on historical trends, current Choice funding may last until the end of May 2018, depending on program utilization. VA has partnered with Veterans, community providers, VSOs, and other stakeholders to understand their needs and incorporate crucial input into the concept for a consolidated VA community care program. Currently, VA is working 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. The time to act is now, and we need your help.

In FY 2019, the Budget reflects 14.2 billion in total obligations to support community care for Veterans. This includes an additional $2.4 billion in discretionary funding that is now available as a result of the recently enacted legislation to raise discretionary spending caps. Of this amount, $1.9 billion replaces the mandatory funding that was originally requested in FY 2018 to be carried over into FY 2019. This funding will be used to continue the Choice Program for a portion of FY 2019 until VA is able to fully implement the Veteran CARE program. The remaining $500 million will support VA's traditional community care program in FY 2019. The Administration would also support using discretionary funding provided in FY 2018 in the cap deal to ensure that the Choice Program can continue to operate for the remainder of FY 2018.

Finally, the Budget transitions VA to recording community care obligations on the date of payment, rather than the date of authorization. This change in the timing of obligations results in a one-time adjustment of $1.8 billion, which would support a total 2019 program level of $14.2 billion for community care needs.

Forever GI Bill

In addition to expanding choice in health care, the Harry W. Colmery Veterans Educational Assistance Act of 2017 or the Forever GI Bill contains 34 new provisions, the vast majority of which will enhance or expand education benefits for Veterans, Servicemembers, Families and Survivors. Most notably, this new law removes the 15-year time limitation for Veterans who transitioned out of the military after January 1, 2013, to use their Post-9/11 GI Bill benefits. This law also restores benefits to Veterans who were impacted by school closures since 2015, expands benefits for certain Reservists, surviving dependents, Purple Heart recipients, and provides many other improvements. Thirteen of the 34 provisions were effective on the date of enactment, while the remaining provisions have future effective dates ranging from January 1, 2018, to August 1, 2022.

Closing

Thank you for the opportunity to appear before you today to address our FY 2019 budget and FY 2020 AA budget requests. These resources will honor the President's commitment to Veterans by continuing to enable the high quality care and benefits our Veterans have earned. They will support my efforts to achieve my top priorities while ensuring that VA is a source of pride for Veterans, beneficiaries, employees, and taxpayers. I ask for your steadfast support in funding our full FY 2019 and FY 2020 AA budget requests and continued partnership in making bold changes to improve our ability to serve Veterans. I look forward to your questions.

Statements For The Record

THE INDEPENDENT BUDGET

Budget Recommendations for FY 2019 and FY 2020

Introduction

For more than 30 years, the co-authors of The Independent Budget-DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars (VFW)-have presented our budget and policy recommendations to Congress and the Administration. Our recommendations are meant to inform Congress and the Administration of the needs of our members and all veterans and to offer substantive solutions to address the many health care and benefits challenges they face. This budget report serves as our benchmark for properly funding the Department of Veterans Affairs (VA) to ensure the delivery of timely, quality health care and accurate and appropriate benefits.

The Independent Budget veterans' service organizations (IBVSOs) recognize that Congress and the Administration continue to face immense pressure to reduce Federal spending. However, we believe that the ever-growing demand for health care and benefits, particularly with more health care being provided in the community and purchased by VA, certainly validates the continued need for sufficient funding. We understand that VA has fared better than most Federal agencies in budget proposals and appropriations, but the real measure should be how well the funding matches the demand for veterans' benefits and services.

We appreciate that Congress remains committed to doing the right thing and has continued to provide increases in appropriations dollars. However, the serious access problems in the health care system identified in 2014, and the continued pressure being placed on the claims processing system, raise serious questions about the adequacy of resources being provided and how VA chooses to spend these resources.

The IBVSOs are jointly releasing this report on the budget for VA and our projections for VA's funding needs across all programs. In submitting our recommendations the IBVSOs are attempting to produce an honest assessment of need that is not subject to the politics of Federal budget development and negotiations that inevitably have led to continuous funding deficits.

Our recommendations include funding for all discretionary programs for FY 2019 as well as advance appropriations recommendations for medical care accounts for FY 2020. The FY 2019 projections are particularly important because VA has been operating under a continuing resolution nearly halfway through FY 2018 without the additional resources necessary to meet all the requirements and initiatives of the Department. We hope that Congress will take this defined shortfall very seriously and appropriately address this need. Our own FY 2019 estimates affirm this need, which is based pending FY 2018 appropriations bills.

We hope that the House and Senate Committees on Veterans' Affairs as well as the Military Construction and Veterans' Affairs Appropriations Subcommittees will be guided by these estimates in making their decisions to ensure sufficient, timely, and predictable funding for VA.

VA Accounts for FY 2019 and FY 2020 Advance Appropriations

	FY 2018* Appropriation	FY 2019 Admin Revised	FY 2019* Independent Budget	FY 2020 Admin Request	FY 2020 IB Independent Budget
Veterans Health Administration (VHA)					
Medical Services	48,732,554	49,161,165	53,661,274	63,167,774	54,687,544
Medical Community Care	9,663,118	8,384,704	14,752,153	-	14,973,092
Choice Program**	2,100,000	1,900,000		-	
Subtotal Medical Services	***60,495,672***	***59,445,869***	**68,413,427**	***63,167,774***	**69,660,636**
Medical Support and Compliance	6,754,480	7,239,156	6,838,244	7,106,150	7,367,749
Medical Facilities	6,141,880	5,914,288	7,389,736	5,276,676	7,506,132
Subtotal Medical Care, Discretionary	**73,392,032**	**72,599,313**	**82,641,407**	**75,550,600**	**84,534,517**
Medical Care Collections	*3,254,968*	*3,443,133*		*3,580,999*	
Total, Medical Care Budget Authority (including Collections)	***76,647,000***	***76,042,446***	***82,641,407***	***79,131,599***	***84,534,517***
Medical and Prosthetic Research	722,262	727,369	758,000		
Million Veteran Program			65,000		
Total, Veterans Health Administration	**77,369,262**	**76,769,815**	**83,464,407**		
General Operating Expenses (GOE)					
Veterans Benefits Administration	2,910,000	2,868,909	3,103,711		
General Administration	329,891	367,629	354,639		
Board of Veterans Appeals	166,000	174,748	167,624		
Total, General Operating Expenses (GOE)	**3,405,891**	**3,411,286**	**3,625,974**		
Departmental Admin and Misc. Programs					
Information Technology	4,055,500	4,184,571	4,103,698		
IT Modernization		1,207,000	*1,600,000*		
National Cemetery Administration	306,193	315,836	310,811		
Office of Inspector General	164,000	172,054	167,811		
Total, Dept. Admin. and Misc. Programs	**4,525,693**	**5,879,461**	**6,182,315**		
Construction Programs					
Construction, Major	512,430	1,127,486	1,730,000		
Construction, Minor	342,570	706,889	761,000		
Grants for State Extended Care Facilities	110,000	150,000	200,000		
Grants for State Vets Cemeteries	45,000	45,000	51,000		
Total, Construction Programs	**1,010,000**	**2,029,375**	**2,742,000**		
Other Discretionary	180,215	202,196	184,000		
Total, Discretionary Budget Authority (including Medical Collections)	***86,491,061***	***88,292,133***	***96,198,696***		

* Assumes funding levels in S. 1557, the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018.

**Choice Program funding is currently scored as a mandatory cost for VA.

Veterans Health Administration

Total Medical Care

FY 2019 IB Recommendation	$82.6 billion
FY 2019 Revised Administration Request	$72.6 billion
Medical Care Collections	***$3.44 billion***
Total	$76.0 billion
FY 2018 Estimated Final Appropriation	$71.5 billion
Medical Care Collections	***$3.25 billion***
Total	$74.7 billion
FY 2020 IB Advance Appropriations Recommendation	$84.5 billion
FY 2020 Administration Advance Appropriations Request	$75.6 billion
Medical Care Collections	***$3.58 billion***
Total	$79.1 billion

The IBVSOs have serious concerns about VA's current funding level of FY 2018 based on the current continuing resolution funding the Department through the first half of the fiscal year largely based on the Administration's request. Last year,

however, the former Secretary of Veterans Affairs openly admitted that the FY 2018 advance appropriations request was significantly short. He also indicated that the new Administration and Congress would have to correct this shortfall. We are concerned that Congress has not corrected this problem with VA currently operating under a continuing resolution nearly been operating under a continuing resolution nearly halfway through FY 2018 without the additional resources necessary to meet all the requirements and initiatives of the Department.

If legislation is enacted, starting in FY 2019 VA will record community care obligations on the date of payment rather than the date of authorization. This change in the timing of obligations is estimated to result in a one-time availability of funds totaling $1.8 billion. VA also identifies in its budget request $1.9 billion in mandatory budget authority, which it requested in 2018 for the Choice program, to be carried forward into 2019. We are concerned the availability of such funds remains uncertain. If any amounts are not realized, VA must request and Congress must provide these needed resources.

In addition, VA's budget request indicates that VA will begin to implement its proposal to consolidate and streamline its community care programs, known as the Veterans Coordinated Access and Rewarding Experiences (Veteran CARE). With Congress considering different legislative proposals, including expanded eligibility criteria and VA's CARE plan, including several proposals that require congressional action, the direct impact on needed resources to execute this new program must be determined and addressed. Congress must provide the necessary resources to successfully implement any newly enacted community care legislation to ensure veterans receive high quality and timely medical care from VA, and when necessary in the community.

For FY 2019, the IB recommends approximately $82.6 billion in total medical care funding. We are estimating Congress to appropriate $74.7 billion FY 2018 (which includes an assumption of approximately $3.3 billion in medical care collections). Additionally, The Independent Budget recommends approximately $84.5 billion for total Medical Care for FY 2020. This recommendation reflects the necessary adjustment to the baseline for all Medical Care program funding in the preceding fiscal years. Notably, the VA proposes to consolidate the Choice program and Medical Community Care into the Medical Services account for FY 2020.

Medical Services

Appropriations for FY 2019

FY 2019 IB Recommendation	$53.6 billion
FY 2019 Revised Administration Request	$49.2 billion
Medical Care Collections	***3.44 billion***
Subtotal	$52.6 billion
FY 2018 Estimated Final Appropriation	$46.8 billion
Medical Care Collections	***$3.25 billion***
Subtotal	$50.1 billion

For FY 2019, The Independent Budget recommends $53.7 billion for Medical Services. This recommendation is a reflection of multiple components. These components include the following recommendations:

Current Services Estimate	$50,794,232,000
Increase in Patient Workload	$1,636,092,000
Additional Medical Care Program Cost	$1,230,951,000
Total FY 2019 Medical Services	$53,661,274,000

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 1.1 percent increase for pay and benefits across the board for all VA employees in FY 2019.

Our estimate of growth in patient workload is based on a projected increase of approximately 94,000 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 $1.6 billion.

The Independent Budget believes that there are additional projected medical program funding needs for VA. Those costs total over $1.2 billion. Specifically, we believe there is real funding needed to address the array of long-term-care issues facing VA, including the shortfall in non-institutional services due to unremitting waitlist for home and community based services; to provide additional centralized

prosthetics funding (based on actual expenditures and projections from the VA's Prosthetics and Sensory Aids Service); funding to expand and improve services for women veterans; funding to support the recently approved authority for reproductive services, to include in vitro fertilization (IVF); funding to allow VA to meet the costs for emergency care as dictated by the Richard W. Staab v. Robert A. McDonald ruling by the U.S. Court of Appeals for Veterans Claims, and; initial funding for implementation of extending comprehensive caregiver support services to severely ill and injured veterans of all eras.

Long-Term Services and Supports

The Independent Budget recommends a modest increase of $82 million for FY 2019. This recommendation reflects a significant demand for veterans in need of Long Term Services and Supports (LTSS) in 2017 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. This increase in funding also reflects a rebalancing of available resources towards home- and community-based care which will likely yield a commensurate decrease in institutional spending as is being achieved by State with their balancing of spending initiatives.

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 2017 to FY 2018 and the expected continued growth in expenditures for FY 2019.

Women Veterans

The Medical Services appropriation should be supplemented with $500 million designated for women's health care programs, in addition to those amounts already included in the FY 2018 baseline. These funds would allow the Veterans Health Administration (VHA) to hire and train an additional 1,000 women's health providers to meet increasing demand for health services based on the significant growth in the number of women veterans coming to VA for care.

Additional funds are needed to expand and repair VA facilities to meet environment of care standards and address identified privacy and safety issues for women patients. The new funds would also aid VHA in continuing its initiative for agency-wide cultural transformation to ensure women veterans are recognized for their military service and made to feel welcome at VA. Finally, additional resources are needed to evaluate and improve mental health and readjustment services for catastrophically injured or ill women veterans and wartime service-disabled women veterans, as well as targeted efforts to address higher suicide rates and homelessness among this population.

Reproductive Services (to Include IVF)

Congress authorized appropriations for the remainder of FY 2018 and FY 2019 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 2019. 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 2019.

Emergency Care

VA has issued regulations to begin paying for veterans who sought emergency care outside of the VA health care system based on the Staab court ruling by the U.S. Court of Appeals for Veterans Claims. The requested $298 million increase in funding reflects the amounts VA has estimated will need to dispose of pending and future claims through FY 2019.

Extending Eligibility for Comprehensive Caregiver Supports

Included in this year's IB budget recommendation is funding necessary to implement eligibility expansion of VA's comprehensive caregiver support program to severely injured veterans of all eras. Funding level is based on the Congressional Budget Office estimate for preparing the program, including increased staffing and IT needs, and the beginning of the first phase as reflected in our $11 million FY 2019 recommendation.

Medical Services

Advance Appropriations for FY 2020

FY 2020 IB Advance Appropriations Recommendation	$54.7 billion
FY 2020 Administration Advance Appropriations Request	$63.2 billion
Medical Care Collections	***$3.58 billion***
Subtotal	$66.7 billion

The Independent Budget once again offers baseline projections for funding through advance appropriations for the Medical Care accounts for FY 2020. 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 2019 advance appropriations request with mounting requirements. This trend cannot be allowed to continue, particularly as Congress looks for ways to reduce discretionary spending, even when those reductions cannot be justified.

Moreover, VA has proposed to merge programs and resources from the Choice program and Medical Community Care into the Medical Services Account beginning FY 2020. For FY 2020, The Independent Budget recommends approximately $75.7 billion for Medical Services, not including community care recommendation of $10 billion. Our Medical Services level includes the following recommendations:

Current Services Estimate	$51,541,538,000
Increase in Patient Workload	$1,599,848,000
Additional Medical Care Program Cost	$1,546,158,000
Total FY 2020 Medical Services	$54,687,544,000

Our estimate of growth in patient workload is based on a projected increase of approximately 94,000 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 $1.6 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.

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 $326 million, reflecting the ever-growing cost of more advanced prosthetics being prescribed for seriously disabled veterans. We believe that VA should invest a minimum of $509 million as an advance appropriation in FY 2020 to expand and improve access to women veterans' health care programs. Our additional program cost recommendation includes continued investment of over $20 million to support extension of the authority to provide reproductive services to the most catastrophically disabled veterans and VA's cost burden of $309 million for emergency care claims dictated by the Staab ruling. Finally, the FY 2020 recommendation includes an increase of $298 million to provide comprehensive support and services to caregivers of veterans severely injured before September 11, 2001.

Medical Community Care

FY 2019 IB Recommendation	$14.8 billion
FY 2019 Revised Administration Request	$8.38 billion
FY 2018 Estimated Final Appropriation	$9.67 billion
Choice Program	$2.10 billion
Subtotal	$11.8 billion
FY 2020 IB Advance Appropriations Recommendation	$15.0 billion
FY 2020 Administration Advance Appropriations Request	$0.00 billion

For Medical Community Care, The Independent Budget recommends $14.8 billion for FY 2019 and $15 billion for FY 2020. Our recommended increase includes the growth in current services to include current obligations under the Choice program.

The Choice program is a temporary program with mandatory funding provided under an emergency designation. VA received an infusion of $2.1 billion in December 2017 after it notified Congress program resources could be depleted as early as January 2018. While increasing access to community care, the Choice program has in turn increased veterans reliance on VA medical care.

We also believe funding VA programs for community care with a discretionary and mandatory account creates unnecessary waste and inefficiency. The Independent Budget has advocated for moving all funding authorities for the Choice program (and other community care programs) into the discretionary accounts of the VA managed under the Medical and Community Care account.

Medical Support and Compliance

FY 2019 IB Recommendation	$6.84 billion
FY 2019 Revised Administration Request	$7.24 billion
FY 2018 Estimated Final Appropriation	$6.75 billion
FY 2020 IB Advance Appropriations Recommendation	$7.37 billion
FY 2020 Administration Advance Appropriations Request	$7.11 billion

For Medical Support and Compliance, The Independent Budget recommends $6.8 billion for FY 2019. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2018 appropriated level. Additionally, for FY 2020 The Independent Budget recommends $7.3 billion for Medical Support and Compliance. This amount also reflects an increase in current services from the FY 2019 advance level.

Medical Facilities

FY 2019 IB Recommendation	$7.39 billion
FY 2019 Revised Administration Request	$5.94 billion
FY 2018 Estimated Final Appropriation	$6.14 billion
FY 2020 IB Advance Appropriations Recommendation	$7.51 billion
FY 2020 Administration Advance Appropriations Request	$5.28 billion

For Medical Facilities, The Independent Budget recommends $7.3 billion for FY 2019, which includes a $1.2 billion for Non-Recurring Maintenance (NRM). The NRM program is VA's primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments (FCA). These assessments are performed at each facility every three years, and highlight a building's most pressing and mission critical repair and maintenance needs. VA's request for FY 2019 includes $1.4 billion for NRM funding. While the Department has actually spent on average approximately $1.5 billion yearly for NRM, we are concerned its FY 2019 request includes diverting funds programmed for other purposes-$210.7 million from Medical Support and Compliance and $39.3 million from the Medical Services/Medical Community Care accounts.

For FY 2020, The Independent Budget recommends approximately $7.5 billion for Medical Facilities. Last year the Administration's recommendation for NRM reflected a projection that would place the long-term viability of the health care system in serious jeopardy. This deficit must be addressed in light of its $600 million request for FY 2020.

Medical and Prosthetic Research

FY 2019 IB Recommendation	$758 million
Million Veteran Program	$65 million
Total IB Medical and Prosthetic Research	$823 million
FY 2019 Administration Request	$727 million
FY 2018 Estimated Final Appropriation	$722 million

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

Investing Taxpayers' Dollars Wisely

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. As estimated by the Department of Commerce, Bureau of Economic Analysis, and the National Institutes of Health, for VA research to maintain current service levels, the Medical and Prosthetic Research appropriation should be increased in FY 2019 to go beyond simply keeping pace with inflation to make up for how long the continuing resolution funding level for FY 2018 has been in effect.

Numerous meritorious proposals for new VA research cannot be funded without an infusion of additional funding for this vital program. Research awards decline as a function of budgetary stagnation, so VA may resort to terminating ongoing research projects or not funding new ones, and thereby lose the value of these scientists' work, as well as their clinical presence in VA health care. When denied research funding, many of them simply choose to leave the VA.

Emerging Research Needs

In addition to covering uncontrollable inflation, the IBVSOs believe Congress should expand research on emerging conditions prevalent among newer veterans, as well as continuing VA's inquiries in chronic conditions of aging veterans from previous wartime periods. For example, additional funding will help VA support areas that remain critically underfunded, including:

- Post-deployment mental health concerns such as PTSD, depression, anxiety, and suicide in the veteran population;
- The gender-specific health care needs of the VA's growing population of women veterans;
- New engineering and technological methods to improve the lives of veterans with prosthetic systems that replace lost limbs or activate paralyzed nerves, muscles, and limbs;
- Studies dedicated to understanding chronic multi-symptom illnesses among Gulf War veterans and the long-term health effects of potentially hazardous substances to which they may have been exposed; and
- Innovative health services strategies, such as telehealth and self-directed care, that lead to accessible, high-quality, cost-effective care for all veterans.
- Leverage the only known integrated and comprehensive caregiver support program in the U.S. to help inform policy makers and other health systems looking to support informal caregivers.

Million Veteran Program

The VA Research program is uniquely positioned to advance genomic medicine through the "Million Veteran Program" (MVP), an effort that seeks to collect genetic samples and general health information from 1 million veterans over the next five years. When completed, the MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of veterans. To date, more than 620,000 veterans have enrolled in MVP far exceeding the enrollment numbers of any single VA study or research program in the past, and is in fact one of the largest research cohorts of its kind in the world.. The VA estimates it currently costs around $75 to sequence each veteran's blood sample. Accordingly, the IBVSOs recommend $65 million to enable VA to begin processing the MVP samples collected. Congress must begin a targeted investment to go beyond basic, surface level genetic information and perform deeper sequencing to begin reaping the benefits of this program.

General Operating Expenses (GOE)

Veterans Benefits Administration

FY 2019 IB Recommendation	$3.10 billion
FY 2019 Administration Request	$2.87 billion
FY 2018 Estimated Final Appropriation	$2.91 billion

The Veterans Benefits Administration (VBA) account is comprised of six primary divisions. These include Compensation; Pension; Education; Vocational Rehabilitation and Employment (VR&E); Housing; and Insurance. The increases recommended for these accounts primarily reflect current services estimates with the impact of inflation representing the grounds for the increase. However, two of the subaccounts-Compensation and VR&E-also reflect modest increases in requested staffing to meet the rising demand for those benefits and backlogs of pending workload.

The IB recommends approximately $3.104 billion for the VBA for FY 2019, an increase of approximately $194 million over the estimated FY 2018 appropriations level. Our recommendation includes approximately $92 million in additional funds in the Compensation account above current services, and approximately $18 million more in the VR&E account above current services to provide for new full-time equivalent employees (FTEE).

Compensation Service Personnel 900 New FTEEs $92.4 million

In recent years VBA has made significant progress in reducing the claims backlog, which was over 610,000 claims in March 2013. Today, the claims backlog is roughly 79,000 claims, a decrease of 87 percent from its peak, and a decrease of about 18,000 claims compared to one year prior. VA defines a backlogged disability claim as one pending over 125 days. Overall, the total pending claims workload decreased from about 390,000 in January 2017 to just over 320,000 claims today, a decrease of 18 percent in the past year. During that time, the average days to complete a claim dropped from 119 days last year to 103 days this January.

However, the trends on accuracy have gone the other direction. In January 2015, the 12-month issue-level accuracy was approximately 96 percent; today it is down to about 94.5 percent, though it has leveled off over the past eight months. The 12-month claim-based accuracy measurement has dropped from approximately 91 percent in January 2015 to less than 85 percent today. While it is critical to continue reducing the backlog and the time it takes to complete a claim, VBA must refocus on completing claims accurately the first time.

In addition, VBA has a backlog of non-rating related claims, such as for dependency status changes, that must also be addressed in a timely manner. While continued advancements in the functionality of e-Benefits and other IT systems have allowed veterans and their representatives to directly make dependency changes more quickly, this non-rating related workload is too often given low priority status in Regional Offices. VBA must provide the resources and attention necessary to consistently complete this work in a timely manner.

It is also critical that VBA have sufficient funding for IT development and maintenance. In particular, VBA must devote additional resources to stakeholder IT enhancements in order to allow VSOs to more efficiently submit and review claims they represent. This will not only provide better service to veterans, it will also reduce some of the burden and workload that would otherwise fall on VBA personnel.

Another major driver of VBA workload is appeals processing. There were approximately 470,000 pending appeals of claims decisions at various stages between VBA and the Board of Veterans Appeals (Board), with approximately 350,000 requiring further processing at VBA Regional Offices.

Last year, Congress approved the Veteran Appeals Improvement and Modernization Act (P.L. 115–55) in order to help streamline the appeals process and provide better, timelier decisions for veterans. In November, VBA began early implementation of the law through the Rapid Appeals Modernization Program (RAMP) pilot that invites veterans with pending appeals to opt into the new system through the either the Higher Level Review or Supplemental Claim option. RAMP may have the effect of redirecting some workload from the Board back to VBA; however, once implemented, the new law will also eliminate many of the current appeal processes that take place at the Agency of Original Jurisdiction (AOJ), such as Statements of Case, and Form 9 Certification.

Over the past several years, VA has requested, and Congress has provided, additional funding to increase staffing at VBA to address the claims backlog. However,

there have not been commensurate increases in funding to address the backlog of appeals pending inside VBA.

For FY 2019, the IBVSOs recommend an additional 900 FTEE for VBA. Of those, 500 should be allocated to the Compensation Service to address the pending and future appeals workload; another 350 should be allocated to address the growing backlog of non-rating related work, such as dependency claims; and 50 should be allocated to the fiduciary program to address increased workload in recent years, particularly related to veterans participating in VA's Caregiver Support programs. A July 2015 VA Inspector General report on the fiduciary program found, ".Field Examiner staffing did not keep pace with the growth in the beneficiary population, [and] VBA did not staff the hubs according to their staffing plan.." Last year the IBVSOs recommended 100 additional FTEE to address this problem; however, since VBA reallocated an additional 51 FTEE to the fiduciary program this year, the IBVSOs have reduced our recommendation to 50 new FTEE for FY 2019.

Finally, as the Veterans Appeals Improvement and Modernization Act of 2017 continues to be fully implemented, including RAMP, VBA must develop more accurate workload, production and staffing models in order to accurately forecast future VBA resource requirements.

VR&E Service Personnel 143 New FTEEs $18 million

The Vocational Rehabilitation and Employment Service (VR&E), also known as the VetSuccess program, provides critical counseling and other adjunct services necessary to enable service disabled veterans to overcome barriers as they prepare for, find, and maintain gainful employment. VetSuccess offers services on five tracks: reemployment, rapid access to employment, self-employment, employment through long-term services, and independent living.

An extension for the delivery of VR&E assistance at a key transition point for veterans is the VetSuccess on Campus (VSOC) program deployed at 94 college campuses. Additional VR&E services are provided at 71 select military installations for active duty servicemembers undergoing medical separations through the Department of Defense and VA's joint Integrated Disability Evaluation System (IDES).

Over the past four years, program participation has increased by an estimated 16.8 percent, while VR&E staffing has risen just 1.8 percent. VA projects program participation will increase another 3.1 percent in FY 2019, and it is critical that sufficient resources are provided not only to meet this rising workload, but also to expand capacity to meet the full, unconstrained demand for VR&E services.

In 2016, Congress enacted legislation (P.L. 114–223) that included a provision recognizing the need to provide a sufficient client-to-counselor ratio to appropriately align veteran demand for VR&E services. Section 254 of that law authorizes the Secretary to use appropriated funds to ensure the ratio of veterans to Vocational Rehabilitation Counselors (VRC) does not exceed 125 veterans to one full-time employment equivalent. Unfortunately, for the past three years, VA has requested no new personnel for VR&E to reach this ratio.

In order to achieve the 1:125 counselor-to-client ratio established by Congress, the IBVSOs estimate that VR&E will need another 143 FTEE in FY 2019 for a total workforce of 1,585, to manage an active caseload and provide support services to almost 150,000 VR&E participants. At a minimum, three-quarters, of the new hires should be VRCs dedicated to providing direct services to veterans.

General Administration

FY 2019 IB Recommendation	$355 million
FY 2019 Administration Request	$368 million
FY 2018 Estimated Final Appropriation	$330 million

The General Administration account is comprised of 10 primary divisions. These include the Office of the Secretary; the Office of the General Counsel; the Office of Management; the Office of Human Resources and Administration; the Office of Enterprise Integration; the Office of Operations, Security and Preparedness; the Office of Public Affairs; the Office of Congressional and Legislative Affairs; and the Office of Acquisition, Logistics, and Construction; and the Veterans Experience Office (VEO). This marks the first year that the VEO has been included in the divisions of General Administration. Additionally, a number of the divisions reflect changes to the structure and responsibilities of those divisions. For FY 2019, the IB recommends approximately $355 million, an increase of more than $25 million over the

FY 2018 estimated level. This increase primarily reflects an increase in current services based on the impact of uncontrollable inflation across all of the General Administration accounts.

Board of Veterans' Appeals

FY 2019 IB Recommendation	$168 million
FY 2019 Administration Request	$175 million
FY 2018 Estimated Final Appropriation	$166 million

With the enactment of the Veterans Appeals Improvement and Modernization Act (P.L. 115–55), the Board in 2018 will be developing and implementing the new appeals system scheduled to begin in February 2019. Once fully implemented, the Board will operate five separate dockets concurrently, which will require new training and new IT functionality to manage this workload. The Board has presented its implementation plans to Congress and must adhere to the timelines laid out in order to finalize new regulations and prepare its workforce. In addition, sufficient IT resources must be provided to the Board to complete development of new workload management tools.

Once the new appeals system is stood up in 2019, overall workload coming into the Board is expected to begin leveling off, or perhaps begin to decrease, as veterans take advantage of the expanded options to resolve appeals at the AOJ level. Thus, it is too early to project whether the Board will require more or less resources in its future state.

For FY 2018, the Board is projecting that it will produce 81,000 decisions, the highest total in the Board's history, though there will still remain a significant backlog of appeals in the pipeline. VA's budget submission for FY 2018 requested funding to increase FTEE levels to 1,050, continuing staffing increases in recent years to expand capacity and allow the Board to address both the backlog of legacy appeals and the transition to the new appeals system.

For FY 2019, the IBVSOs do not recommend any additional staffing increases at the Board; however, it is critical that the Board complete the hiring and training of new personnel as rapidly as possible. Further, it will be critical for VA and Congress to carefully and regularly monitor workload, timeliness, quality and other metrics to ensure that the Board is and remains appropriately staffed in the future.

Departmental Administration and Miscellaneous Programs

Information Technology

FY 2019 IB Recommendation	$4.10 billion
IT Modernization	***$1.60 billion***
Total	$5.70 billion
FY 2019 Administration Request	$4.18 billion
IT Modernization	***$1.21 billion***
Total	$5.39 billion
FY 2018 Estimated Final Appropriation	$4.06 billion

In contrast to significant department-level IT failures, the Veterans Health Administration (VHA) over more than 30 years successfully developed, tested, and implemented a world-class comprehensive, integrated electronic health record (EHR) system. The current version of this EHR system, based on the VHA's self-developed VistA public domain software, sets the standard for EHR systems in the United States and was a trailblazer for years. However, parts of VistA require either modernization or replacement. For example, one of its component parts, the outdated scheduling module, contributed to VA's recent access to care crisis. According to VA, this module is being replaced on an expedited basis.

For FY 2019, the IBVSOs recommend approximately $4.1 billion for the administration of the VA's IT program. While this recommendation includes no new funding above the planned current services level, we remind Congress of the need to sustain VistA for an estimated 7–10 years after initial operating capabilities is attained at initial sites for IT Modernization proposed by VA. Significant resources have already been invested in VA's IT programs in recent years, and we believe proper allocation of existing resources can allow VA to fulfill its missions while modernizing its systems.

Moreover, Public Law 115–48, the Forever GI Bill, authorized $30 million in FY 2018 and FY 2019 to carry out IT changes and improvements to facilitate timely adjudication of GI Bill applications. IT improvements are vital to the proper implementation of the Forever GI Bill, and the IB recommends Congress appropriates the previously authorized $30 million.

Electronic Health Care Record Modernization.

In testimony before the House Appropriations Subcommittee on Military Construction, Veterans' Affairs, and Related Agency, VA Secretary David J. Shulkin reported the decision to adopt the same electronic health care record as the Department of Defense will cost VA approximately $16 billion over the next 10 years. In the same hearing Secretary Shulkin indicated VA would transfer $782 million from both the Office of Information and Technology (OI&T) and Medical Care accounts to fund efforts related to the EHR modernization.

VA's FY 2019 budget requests includes establishing a Veterans Electronic Health Record account and has reserved $782 million of FY 2108 funds to transfer in this new account. In addition, VA is requesting $1.2 billion in resources to modernize its EHR system. The IBVSOs believe such funds must be appropriated by Congress specifically for the EHR modernization instead of defunding other programs and priorities. To ensure VA properly uses its IT funds, the IBVSOs urge Congress to establish and monitor a separate appropriations account for VA's EHR modernization. The IBVSO's recommend Congress appropriate $1.6 billion for VA's EHR modernization account in FY 2019.

National Cemetery Administration

FY 2019 IB Recommendation	$311 million
FY 2019 Administration Request	$316 million
FY 2018 Estimated Final Appropriation	$306 million

The National Cemetery Administration (NCA), which receives funding from eight appropriations accounts, administers numerous activities to meet the burial needs of our nation's veterans.

In a strategic effort to offer all veterans burial options within 75 miles of their home, the NCA continues to expand and improve the national cemetery system, by adding new and/or expanded national cemeteries. Due to a continued increase in demand for burial space which is not expected to peak until 2022, NCA must continue to expand national cemeteries and provide more burial options for veterans. This much needed expansion of the national cemetery system will help to facilitate the projected increase in annual veteran interments and will simultaneously increase the overall number of graves being maintained by the NCA to 3.7 million in 2018 and 4 million by 2021.

The IBVSOs strongly believe that VA national cemeteries must honor the service and fully supports NCA's National Shrine initiative which ensures our nation's veterans have a final resting place deserving of their sacrifice to our nation. The IBVSOs also support NCA's Veterans Legacy Program, which helps educate America's youth of the history of national cemeteries and the veterans they honor.

In order to minimize the dual negative impacts of increasing interments and limited veteran burial space, the NCA needs to:

- Continue developing new national cemeteries;
- Maximize burial options within existing national cemeteries;
- Strongly encourage the development of state veteran cemeteries; and
- Increase burial options for veterans in highly rural areas.

Budgetary Resources for NCA Programs

With the above considerations in mind, The Independent Budget recommends $311 million for FY 2019 for the Operations & Maintenance of the NCA.

Office of the Inspector General

FY 2019 IB Recommendation	$168 million

FY 2019 Administration Request	$172 million
FY 2018 Estimated Final Appropriation	$164 million

We believe that the work requirements assigned to the Office of Inspector General (OIG) have placed it under great stress and potentially stretched it beyond its capacity. That being said, the IBVSOs believe that the office does not warrant a staffing increase at this time. In light of the substantial increase the OIG received in FY2016, the IB recommends funding of approximately $168 million, based on current services for FY2019.

Construction Programs

Major Construction

FY 2019 IB Recommendation	$1.73 billion
FY 2019 Administration Request	$1.13 billion
FY 2018 Estimated Final Appropriation	$0.51 billion

Each year VA outlines its current and future major construction needs in its annual Strategic Capital Investment Planning (SCIP) process. In its FY 2018 budget submission, VA projected it would take between $55 billion and $67 billion to close all current and projected gaps in access, utilization and safety, including activation costs. Currently, VA has 21 major active major construction projects, which have been partially funded or funded through completion.

In its FY 2018 Budget Request, VA requested and Congress intends to appropriate a significant reduction in funding for major construction projects - between $410 million and $512 million. While these funds would allow VA to begin construction on key projects, many other previously funded sites still lack the funding for completion. One of these projects was originally funded in FY 2007, while others were funded more than five years ago but no funds have been spent on the projects to date. Of the 21 projects on VA's partially funded VHA construction list, eight are seismic in nature. Seismic projects are critical to ensuring VA's facilities do not expose veterans to additional risks during an earthquake or other seismic events.

It is time for the projects that have been in limbo for years, or that present a safety risk to veterans and employees, be put on a course to completion within the next five years. To accomplish this goal, the IBVSOs recommend that Congress appropriate $1.73 billion for FY 2019 to 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.

The IBVSOs also recommend, as outlined in its Framework for Veterans Health Care Reform, that VA realign its SCIP process to include public-private partnerships and sharing agreements for all major construction projects to ensure future major construction needs are met in the most financially sound manner.

Research Infrastructure

State-of-the-art research requires state-of-the-art technology, equipment and facilities. For decades, VA construction and maintenance appropriations have not provided the resources VA needed to maintain, upgrade or replace its aging research laboratories and associated facilities. The average age of VA's research facilities is more than 50 years old, and those conditions are substandard for state of the art research.

The IBVSOs believe that Congress must ensure VA has the resources it needs to continue world class research that improves the lives of veterans and helps recruit and retain high-quality health care professionals to work at VA. To do so, Congress must designate funds to improve specific VA research facilities in FY 2019 and in subsequent years. In order to begin to address these known deficits, the IBVSOs recommend Congress approve at least $50 million for up to five major construction projects in VA research facilities.

Minor Construction

FY 2019 IB Recommendation	$761 million
FY 2019 Administration Request	$706 million
FY 2018 Estimated Final Appropriation	$343 million

In FY 2018, VA requested $372 million for minor construction projects. Currently, approximately 900 minor construction projects need funding to close all current and future year gaps within the next 10 years. To complete all of these current and projected projects, VA will need to invest between $6.7 and $8.2 billion over the next decade.

To ensure that VA funding keeps pace with all current and future minor construction needs, the IBVSOs recommend that Congress appropriate an additional $761 million for minor construction projects. It is important to invest heavily in minor construction because these types of projects can be completed faster than other capital infrastructure projects, and have a more immediate impact on services for veterans.

Grants for State Extended-Care Facilities
(State Home Construction Grants)

FY 2019 IB Recommendation	$200 million
FY 2019 Administration Request	$150 million
FY 2018 Estimated Final Appropriation	$110 million

Grants for state extend-care facilities, commonly known as state home construction grants, are a critical element of federal support for state veterans' homes. The state veterans' home program is a very successful federal-state partnership in which VA and states share the cost of constructing and operating nursing homes and domiciliaries for America's veterans. State homes provide more than 30,000 nursing home and domiciliary beds for veterans, their spouses and gold-star parents of deceased veterans. Overall, state homes provide more than half of VA's long-term-care workload, but receive less than 22 percent of VA's long-term-care budget. VA's basic per diem payment for skilled nursing care in state homes is significantly less than comparable costs for operating VA's own long-term-care facilities. This basic per diem paid to state homes covers approximately 30 percent of the cost of care, with states responsible for the balance, utilizing both state funding and other sources.

States construction grants help build, renovate, repair, and expand both nursing homes and domiciliaries, with states required to provide 35 percent of the cost for these projects in matching funding. VA maintains a prioritized list of construction projects proposed by state homes based on specific criteria, with life and safety threats in the highest priority group. Only those projects that already have state matching funds are included in VA's Priority List Group 1 projects, which are eligible for funding. Those that have not yet received assurances of state matching funding are put on the list among Priority Groups 2 through 7.

With almost $1 billion in state home projects still in the pipeline, the IBVSOs recommend $200 million for the state home construction grant program to address a portion of the projects expected to be on the FY 2019 VA Priority Group 1 List when it is released this year.

Grants for State Veterans Cemeteries

FY 2019 IB Recommendation	$51 million
FY 2019 Administration Request	$45 million
FY 2018 Estimated Final Appropriation	$45 million

The State Cemetery Grant Program allows states to expand veteran burial options by raising half the funds needed to build and begin operation of state veterans cemeteries. NCA provides the remaining funding for construction and operational

funds, as well as cemetery design assistance. Funding additional projects in FY 2019 in tribal, rural and urban areas will provide burial options for more veterans and complement VA's system of national cemeteries. To fund these projects, Congress must appropriate $51 million.

Questions For The Record

HVAC TO VA

Questions for the Record
House Committee on Veterans' Affairs
"U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2019"

February 15, 2018
Questions for the Record from Chairman Roe:
Question 1: Current appropriations into the Choice Program fund are projected to last through the end of fiscal year 2018. How much additional funding is needed to sustain the program through the enactment and implementation of community care consolidation legislation, and is all such funding provided in the Bipartisan Budget Act of 2018, P.L. 115-123 and its resulting allocations?
a. Please answer the above questions assuming a March 2019 implementation.
b. Please answer the above questions assuming any other implementation date that VA believes is appropriate or may become appropriate.

VA Response: The Bipartisan Budget Act of 2018 provided the necessary funds to support the Veterans Choice Program with mandatory resources through May of 2019. VA strongly supports the MISSION Act and thanks Congress for its enactment of this top Administration priority. The fiscal year (FY) 2019 Budget fully funded Community Care, but assumed enactment by February 2018 of community care consolidation legislation (CARE, as proposed by VA). Due to the delay in enactment, VA will require an additional $1.6 billion in FY 2019 for VA's traditional community care program. In addition, the final MISSION Act included expanded eligibility and new programs that were not included in the VA's FY 2019 or FY 2020 Advanced Budget Request.

Question 2: Assuming enactment and implementation of community care consolidation legislation, considering VA's budget request for fiscal year 2019 appropriations, fiscal year 2020 advance appropriations, and additional funding provided in the Bipartisan Budget Act and its resulting allocations, would community care programs be fully funded in fiscal years 2019 and 2020?

VA Response: The FY 2019 Budget fully funded Community Care, but assumed enactment by February 2018 of CARE legislation. Due to the delay in enactment, VA will require an additional $1.6 billion in FY 2019 for VA's traditional community care program. This does not include the additional funding due to new unfunded MISSION Act programs and expanded eligibility.

Question 3: Many of the figures in the Department's budget proposal assume VA legislative proposals have already been enacted.

a. If all legislative proposals are not enacted by the beginning of fiscal year 2019, assuming the proposed funding levels were enacted, would those funding levels be sufficient and those budget projections remain accurate?

VA Response: There are a few proposals that, with delayed enactment, will increase costs. One that is particularly impactful and therefore concerning is a provision enacting Medicare rates for the new Community CARE program. Delay would increase VA's costs for its traditional community care program by approximately $1.6 billion in FY 2019 (as noted above in the response to Roe, Question 1).

b. If the community care consolidation proposal is not enacted by the beginning of fiscal year 2019, assuming the proposed funding levels were enacted, would those funding levels be sufficient and those budget projections remain accurate?

VA Response: The MISSION Act provided the necessary funds to support the Veterans Choice Program with mandatory resources through May of 2019. VA strongly supports the MISSION Act and thanks Congress for its enactment of this top Administration priority. The FY 2019 Budget fully funded Community Care, but assumed enactment by February 2018 of CARE legislation. Due to the delay in en-

actment, VA will require an additional $1.6 billion in FY 2019 for VA's traditional community care program. In addition, the final MISSION Act included expanded eligibility and new programs that were not included in the VA's FY 2019 or FY 2020 Advanced Budget Request.

c. If the legislative proposals regarding construction and leasing thresholds and joint facilities authorities are not enacted by the beginning of fiscal year 2019, assuming the proposed funding levels were enacted, would those funding levels be sufficient and those budget projections remain accurate?

VA Response: Yes, even if the legislative proposals are not enacted by FY 2019, the funding levels would be sufficient to cover cost for these programs.

Question 4: VA's budget request represents a historic increase for the Department, larger in percentage terms than for any other agency. The budget narrative mentions ″modernization reforms and other efficiencies.″ What are the top 10 proposed reforms or efficiencies that will produce savings, ranked in order of dollar value? Such savings should not be offsets for other spending increases but rather efficiencies, programmatic, administrative, or otherwise, that will produce tangible savings measured against current expenditures.

a. How will veterans experience the proposed reforms, efficiencies, and savings, and how will VA services be impacted?

b. How will the reforms, efficiencies, and savings impact access to care?

VA Response: VA is modernizing to improve performance and to better serve Veterans, their families, caregivers, and survivors while being good stewards of tax payer dollars. Guided by both the Secretary's priorities and the President's Executive Order (EO), ″Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce,″ VA is focused on reducing bureaucracy; simplifying core functions; increasing accountability; encouraging bold and decisive leadership; streamlining services and programs by eliminating redundancies; and empowering employees to do the right things for Veterans.

In developing this plan, VA reviewed numerous studies and assessments that project potential cost savings or avoidance as a result of these modernization efforts. While we are still evaluating the tangible and intangible benefits associated with each initiative, we believe there are specific cost reduction opportunities in several areas, including our contact centers and supply chain as detailed below.

Modernization is not a one-time effort to make updates: these are significant changes that will advance internal and external operations. The following provides insight into how the Department is modernizing to improve efficiency and delivery of care and services for Veterans.

1. *Telehealth:* VA will continue to leverage Telehealth technologies to enhance accessibility, capacity, and quality of VA healthcare. By expanding Telehealth capabilities, VA seeks to increase access to services for Veterans living in rural and remote locations, increase availability of specialty services, and reduce the volume of onsite patient care.

2. *Community Care:* VA has submitted, and Congress has passed a plan for consolidating several programs that provide community care through non-VA providers into a new, single VA Community Care program in FY 2018. This will expand access to care by allowing Veterans to obtain health care services outside the Veterans Health Administration (VHA) if those services are not available or readily accessible within VHA. Consolidating programs under a single executive will improve accountability and provide VA with the ability to direct funding for non-VA care to emerging high-priority needs as appropriate.

3. *Change in Timing of Obligations:* The FY 2019 Budget includes a one-time savings of $1.8 billion from changing the time of community care obligation. The proposed accounting change will mean that obligations will be recorded at the time claims are processed and approved, thereby eliminating the uncertainty regarding the actual total obligations against the program. The Department believes that this change in obligation procedure will improve program management and the ability to forecast and justify budget requirements.

4. *Appeals Modernization:* Working collaboratively with stakeholders to implement legislative change by February 2019, Veterans Benefits Administration (VBA) and the Board of Veteran Appeals (Board) will address the current pending inventory of legacy appeals and implement a streamlined process. This effort will shorten the

time to process appeals; increase transparency of the appeal process; and reduce the amount of time and resources required to process appeals.

5. *Suicide Prevention:* Reducing suicide among Veterans is VA's top clinical priority and VA is implementing a comprehensive strategy (e.g., leveraging Federal, state, local, private, services and benefits) to reduce suicide from its current rate of approximately 20 Veterans per day.

6. *IT Modernization:* This initiative will replace legacy IT systems and infrastructure with modern technologies and applications in order to overcome security and business requirement deficiencies. VA currently has more than 130 legacy systems that place the Department at considerable risk of being unable to deliver care and benefit services. This effort will increase responsiveness, agility and flexibility while reducing recurring costs necessary to sustain outdated, legacy systems.

7. *Electronic Health Record Modernization (EHRM):* On May 17, 2018, VA signed a contract with Cerner to modernize its Electronic Health Record (EHR) by replacing the legacy VISTA system and adopting/deploying a common system being deployed by the Department of Defense (DoD). It is one of the largest IT contracts in the federal government, with a ceiling of $10 billion over 10 years. When complete, this will increase interoperability, accuracy of information, responsiveness and access to care, reliability, transparency and accountability while reducing improper payments.

8. *Financial Management Business Transformation:* VA's Financial Management Business Transformation (FMBT) will replace VA's legacy Financial Management System by providing a modern, integrated financial management and acquisition solution. FMBT will increase the transparency, accuracy, timeliness, and reliability of financial and acquisition information across VA, resulting in improved fiscal accountability to American tax payers and an increased standard of excellence for Veterans and those who serve them.

9. *Navigator - Contact Center Modernization:* VA is transitioning its contact centers away from antiquated, fragmented, legacy systems to an agile, innovative cloud solution to optimize responses to the 140 million calls flooding VA's 1,000+ toll-free and direct dial numbers annually. Specifically, best practices for enterprise contact centers include use of a tiered structure to drive calls to the least expensive tier capable of responding to the callers' needs. By implementing such a structure VA expects to realize enterprise operating cost avoidance for labor standardization and first call resolution that exceeds $400 million annually. Additionally, a centralized source of data and interaction history will enable VA to make data-driven, Veteran-focused improvements.

10. *Improving Foundational Business Functions:* VA is restructuring its central office functions to become more agile and responsive. This includes consolidating redundant functions, delayering and pushing decision rights to the lowest appropriate level, improving processes and technology, and redirecting resources from headquarters to the field to support delivery of services to Veterans. The following three examples illustrate progress on this initiative:

a. *Supply Chain Modernization:* Modernizing VA supply chain to a streamlined, responsive enterprise supply chain will significantly enhance the delivery of care and service in a timely fashion. Applying the insights from the Commission on Care (e.g., recommendation #8, ″Transform the management of the supply chain″, which described the organizational structure as ″chaotic″ and noted that ″processes are not aligned to business functions.″), and several independent analyses, VA achieved cost avoidance in excess of $150 million in each of last 2 FYs. This effort will drive accountability and consistency across VA, gaining efficiencies that better serve Veterans, taxpayers, and VA clinicians while contributing to improvements in patient safety, quality of care, access to care, and allocation of clinical resources.

b. *Human Resources (HR) Modernization:* VA is seeking to gain efficiencies by consolidating HR transactional service capabilities; business functions and upgrading HR information technology systems. This will improve performance of HR functions and result in efficiencies through process consolidation and reform.

c. *Construction and Facilities Management:* VA is assessing options to establish a unified, fully integrated enterprise construction and facilities management function through the realignment of operational components currently dispersed among 7 offices and 19 sub-offices. This initiative is in accordance with findings and recommendations from the Commission on Care Independent Assessment Section K, United States Army Corps of Engineers and Defense Health Agency reviews. The

positive impacts include reduction of needless bureaucratic hurdles and resultant wasted staff time and effort. In addition, the referenced studies indicate that (depending upon the ultimate realignment) considerable savings are possible via: appropriate capital facilities inventory; elimination of redundant staff; streamlined procedures; reduced facility maintenance costs; discretionary redirection of facility management savings, and more. These effects will allow for improvements in delivery speed in providing modern efficacious facilities for Veterans' point of health-care delivery. Though it will require time, a direct benefit to Veterans is that VA will be more enabled to strategically address the $19 billion Facility Condition Assessment backlog of deficient findings. The long-term result will be more reliable, better designed facilities allowing for better patient access, scheduling and throughput.

While each initiative is intended to ultimately benefit Veterans, the following table summarizes which initiatives will have a direct impact to Veterans and access to care.

Modernization Initiatives	Direct Impact to Veterans	Direct Access to Care
Telehealth	X	X
Community Care	X	X
Change in Timing of Obligation Appeals Modernization	X	
Suicide Prevention	X	X
IT Modernization	X	X
Electronic Health Record	X	X
Financial Management Business Transformation Navigator	X	X
Delayering VA Central Office	X	X
-HR Modernization -Supply Chain Modernization		X
-Construction and Facilities Management		X

Question 5: Written testimony indicated VA has taken steps to achieve mandatory savings of $30 billion over the next 10 years. Is that a $30 billion savings or a slowing of the rate of spending growth of $30 billion over the next 10 years?

VA Response: The reduction in mandatory spending will be achieved through administrative reforms that will result achieve $30 billion in savings beginning in FY 2021.

Question 6: Please detail how the growth rate of VA's mandatory expenditures will be reduced.

VA Response: Given medical advancements in treatment and other technologies, there has been a decrease in the impacts of certain disabilities on the lives of many Veterans. VA will realize savings by promoting the well-being and enhanced functioning of Veterans and conducting administrative reviews of the disability compensation criteria.

Question 7: Under the proposed Electronic Health Records Modernization (EHRM) program and its contract which has now been essentially completely negotiated, please describe the end states of interoperability with the Defense Department and with VA community providers which will be achieved at the end of two, five, and ten years.

VA Response: VA will leverage a business and technical solution that will help to ensure the health and safety of Veterans through a new EHR interoperable with DoD and community providers. VA will continue to work closely with DoD to implement their lessons learned and optimize VA's prospective schedule. At the end of implementation, VA will achieve interoperability across the Department, between

DoD, and amongst VA community care providers. VA is cautiously balancing the timeline of implementation of the EHR with risk to cost, schedule, and performance objectives.

Question 8: When does VA project to reach a ″break-even point″ after completing EHRM, comparing the costs of carrying out the program and sustaining its future-state systems against the known costs of sustaining current systems, including VistA, CPRS, and all others which are slated for replacement?

VA Response: The EHRM Program Executive Office (PEO) is planning efforts to generate the data needed to conduct a ″break-even point″ analysis. These types of analyses are complex. These efforts include gathering the data needed to estimate EHRM's total life-cycle costs to help the program understand the costs that will have an impact and when these costs will occur. In addition, PEO is working through plans to understand the regional aspects of nationally deployed systems that can be depreciated and estimating the cost savings as a result. Finally, PEO will collaborate with counterparts in the Office of Information & Technology to understand and validate current development, maintenance and sustainment costs.

Question 9: In what year does VA expect completely to phase out VistA and CPRS, assuming the EHRM program's scheduled progress is achieved through its completion?

VA Response: We expect VistA to operate in parallel with the Cerner Millennium solution for a period of time that has yet to be determined. Our Initial Operating Capability (IOC) site implementation in the Pacific Northwest over the first 18 months of EHR implementation following contract award will solidify our ″pivot plan″ for when we will be able to transition from VistA-delivered functionality at a site to the new EHR solution without compromising our Veteran care objectives. These findings at IOC will be used to support full enterprise deployment timelines and corresponding site transitions from VistA to the state-of-the-market EHR.

Question 10: The budget proposal includes funding within the Electronic Health Record Modernization Infrastructure Support line item for continued VistA Standardization. How will VA ensure the ongoing VistA standardization effort will not impede progress to implement the Cerner EHR?

VA Response: It is expected that the current VistA Standardization work will be completed at the beginning of FY 2019. Furthermore, VA anticipates additional work on a limited scope for data dictionary normalization as a part of the VistA Standardization work. The funding would also address some potential portions of VistA and CPRS that will need to be standardized with the new commercial EHR. This would provide best practices in certain workflows from the new EHR to VistA and CPRS.

Question 11: As presented in VA's annual agency financial report, the Department's total budgetary resources in fiscal year 2017 were approximately $229 billion. Assuming the Department's total FY 2019 request of $198.6 billion is granted, how much are the total budgetary resources expected to be?

VA Response: The $229 billion in total budgetary resources identified in the annual Agency Financial Report (AFR) represents the Department's total spending authority in FY 2017. In addition to appropriations, this figure includes collections from revolving funds (Medical Care Collections Fund [MCCF], Canteen, Supply, Franchise, others), unobligated balances, including VA' mandatory programs, and borrowing authority.

VA's 2019 President's Budget request complies with scoring practices established by the Office of Management and Budget (OMB). The AFR includes off-budget authority and unobligated balances, which are identified in the budget. Therefore, the President's Budget is the most accurate representation of VA's request for new appropriations in FY 2019.

Question 12: VA previously proposed recording community care obligations at the time of payment, rather than estimating them in advance and then reconciling actual expenditures. VA has determined it has the authority, without legislation, to start doing so at the beginning of fiscal year 2019. The proposed community care budget assumes a favorable, one-time change in the timing of obligations worth $1.8 billion. Please explain in detail how this number was developed.

VA Response: VA used the historical FY 2015 and FY 2016 inpatient and outpatient payment data to determine the FY 2019 $1.8 billion one-time timing of obligations savings. VA analyzed that on average, it takes about 3 months from the

time VA receives a claim from community care providers to adjudicate and to make final payments to its community care providers. VA also determined that 92 percent of the accrued obligations (those not executed in the current fiscal year) resulted in a payment within 2 years. VA anticipates minimal obligations during the first 3 months of FY 2019, the first year of the transition to recording the obligation at the time of adjudication. VA will continue to process payments (expenditures) for care obligated prior to FY 2019 using the previous methodology (obligate at time of authorization) to reconcile actual expenditures.

Question 13: The proposed community care budget relies on $1.38 billion of ″transfers, unobligated balances, and recoveries″ in fiscal year 2019. Please explain what this number contains and how each element of the overall total was developed.

VA Response: Please see the chart below.

Dollars in Thousdands ($000)

Description	2019 Revised Request
Transfers (+/-)	
Medical Community Care Transfer to Medical Facilities (0162)	($39,334)
Medical Community Care Transfer to FHCC (0169)	($26,504)
Transfer from Medical Services (0160) to Medical Community Care (0140)	$446,000
Subtotal	**$380,162**
Unobligated Balances	
Unobligated Balance (SOY)	$1,000,000
Unobligated Balances (EOY)	$0
Subtotal	**$1,000,000**
Prior Year Recoveries	**$0**
Total	**$1,380,162**

Transfer

- Proposed transfer of $39.334 million to Medical Facilities will support estimated obligations of $6.145 billion, which includes anticipated Non-Recurring Maintenance obligations of $1.446 billion.
- Proposed transfer of $26.504 million to the Joint-DoD VA Medical Facility Demonstration Fund will support estimated obligations of $449 million.
- Transfer of $446 million from Medical Services to Medical Community Care will support estimated obligations of $10.515 billion. In FY 2019 the budget submission proposes to merge the Medical Community Care appropriation with the Medical Services appropriation. For purposes of responding to this question, Medical Community Care is shown separately.

Unobligated Balances

- Estimated $1 billion in funds remaining (carryover from FY 2018 into FY 2019) from Medical Community Care. Medical Community Care obligations estimate in FY 2018 is $9.363 billion. Funds will be utilized in FY 2019 to support Medical Community Care obligations of $10.515 billion.

Prior Year Recoveries

- Prior Year Recoveries estimate is $0.

Question 14: The budget includes a legislative proposal to grant VA general transfer authority between discretionary accounts up to 2 percent of the Department's total discretionary appropriations. This year, VA's discretionary request is a little over $83 billion, excluding medical care collections; 2 percent of that total equates to approximately $1.7 billion. Please provide examples when it has been necessary to transfer this much funding and complying with the existing congressional notification process hampered the Department's operations.

VA Response: The Department's request for General Transfer Authority of 2 percent would provide the needed flexibility to manage unanticipated needs during the FY. One recent example where this authority would have provided the Department the flexibility to address unplanned requirements was the proposed transfer of funding for the EHR initiative. This flexibility would have allowed VA to adapt quickly to changing requirements and optimize resources in FY 2018 by reallocating underexecuting requirements to the next prioritized requirement.

Question 15: The budget proposal contains a narrative contending the separate Community Care account has restricted VA medical center directors from managing their budgets effectively. Please provide specific examples of this.

VA Response: The Budget proposes to merge the Medical Community Care appropriation with the Medical Services appropriation, as was the case prior to 2017. The current multiple medical care appropriations structure, including mandatory and discretionary resources, presents a significant administrative burden to the Medical Center Directors. While not insurmountable, it does not permit the Medical Center leadership to easily leverage all the tools available for providing Veterans with the care they need. Having both Medical Services and Medical Community Care (MCC) aligned under one appropriations account would allow Medical Center Directors the flexibility needed to expediently address care-related issues in ways that are beneficial to our Veterans.

1. Prior to the implementation of the MCC account, VA medical centers locally allocated funds between VA Medical Center (VAMC) salaries and care in the community, ensuring Veterans had timely access to care. This flexibility was lost with the creation of the MCC account. This proposal allows the previous flexibility while ensuring timely access to care and to strategically and efficiently use the funds. Below are specific examples.

a. A VAMC has a physician vacancy that has been unfilled for some time, but is able to finally hire someone for that position. Because the workload associated with this new hire would have been reflected in community care in the recent past, the VAMC would like to move the funds back in-house and provide the care at lower cost, rather than purchasing it from the community. Under the current appropriation structure, moving this position from community care back into VA requires a time consuming transfer process, and in the interim, the VAMC must identify in-house funding offsets that could limit clinical care in another area.

b. A rural VAMC provides 1,200 sleep studies each month through care in the community at a cost of $864,000 a year. Total estimated staffing and supply costs to bring those services in-house is estimated to be $450,000 a year, but the process of transferring funds between appropriations accounts is time consuming and administratively burdensome causing the medical center to purchase sleep studies in the community at almost twice the cost of providing the care in-house.

c. A VAMC has sufficient operating room capacity, outpatient clinical space, and equipment to provide clinical services, but lacks the flexibility to convert community care funds to medical services funds in a timely manner. As a result, the operating rooms may sit idle since the VAMC cannot access ″community care funds″ to pay for these procedures in-house.

2. The current multiple medical care appropriations structure also negatively impacts existing sharing agreements with adjacent university hospitals. VA sharing agreements are funded with the Medical Services appropriation. When medical centers exceed the annual allotted budget for the sharing agreement(s), the medical center is required to send Veterans for care in the community for the remainder of the fiscal year. For specialty care, such as orthopedic surgeries, the cost is frequently much more costly than through the sharing agreement. With a consolidated account, a VAMC could provide these services in-house, likely at a lower rate than what may be available in the community.

3. Strategic investment in capital equipment and staffing is limited without the flexibility to transfer funds expeditiously between appropriations. With the combined appropriation, medical center directors would have more flexibility to reallocate the MCC funds to purchase necessary equipment as well as to fund necessary salaries. As one specific example, a VAMC currently sends out all low-dose Computerized Tomography scans to the community at an average cost of $200 a scan. The VAMC would like to realign the community care funds to provide this service in-house at an average cost of $125 with equipment and staff capacity.

Question 16: If the Medical Services and Community Care accounts are merged as requested, how would VA ensure that each Veterans Integrated Service Networks (VISN) and VAMC allocates sufficient funding to community care, and does not deny veterans access to community providers in order to maintain their internal budgets, as happened not infrequently before the accounts were separated?

VA Response: VA uses an actuarial model, the Enrollee Health Care Projection Model (EHCPM), to develop health care requirements for Veterans. The EHCPM develops estimates for both community care and care provided in VAMCs. If VA's proposed change were made, VA would continue to include separate estimates for community care funded within the Medical Services appropriation in the President's Budget request. VA would also continue to discretely account for community care obligations using the same underlying accounting structure currently in place for the separate Medical Community Care appropriation. Concurrent with the request to combine the Medical Services and Medical Community Care appropriations accounts, VA is submitting a legislative proposal to allow VA to use a model similar to that used for the Consolidated Mail Outpatient Pharmacy program, where the funds will initially reside with each VAMC, but will be provided by the VAMC to the Deputy Under Secretary for Community Care to manage during the year. Based on the demand for community care and the ability of the VAMC to provide more care in house at lower cost, the amount provided can be rapidly adjusted to meet changes in each VAMC's ability to provide care in-house.

Question 17: What is the VISN's role in making sure facilities within its boundaries have enough funds to cover contingencies in either the Medical Service or Community Care accounts?

VA Response: The VISN is responsible for establishing emergency reserve funds in the Medical Service account. The reserve fund allows the VISN to address contingencies. VISN leadership routinely identifies needs/excess and realigns funds between facilities as needed.

Question 18: How does this budget proposal contemplate absorbing additional demand or utilization that may result from community care consolidation?

VA Response: The FY 2019 Budget request fully funded VA's Community Care needs consistent with the assumptions identified below.

- The FY 2019 Budget includes $14.2 billion in total programmatic resources after adjusting for the impact of the one-time change in timing of obligations.
- The Budget increases VA's ability to manage limited resources by funding all community care entirely with discretionary funds and by merging the Medical Community Care appropriation account with the Medical Services account. These flexibilities, combined with the efficiencies included in the CARE legislation, will empower VA to focus and manage resources without requiring subsequent bailouts.
- VA will continue to work with Congress and stakeholders to improve Veterans health care and maximize the quality, efficiency, and fiscal sustainability of VA's community health program.

The MISSION Act provided the necessary funds to support the Veterans Choice Program with mandatory resources through May of 2019. The delay in enacting the new community care program could require an additional $1.6 billion in FY 2019 for VA's traditional community care program. In addition, the FY 2019 Budget did not include funding to support some of the unfunded programs included in Mission or the expanded eligibility.

Question 19: The budget proposal states VISN and medical center leaders are being asked to assess community care options to give veterans greater convenience. Please provide a copy of the policy creating this directive and explain how it was disseminated.

VA Response: Currently, there is no policy. However, VA facility and VISN leaders continue to assess options for health services that could be more conveniently delivered by community providers. VA leaders are also considering accessibility of VA facilities and convenience factors (like weekend hours), as they develop recommendations for community access to non-VA providers for Veterans in their service areas. Defining VA-delivered foundational services and a process for determining which services VA should deliver in its own facilities and which services VA should purchase from community providers and Federal partners will enable VA to provide access to high-quality care for Veterans by balancing care provided by VA and the

community/partners while addressing the increasing demand for care. Increased operational efficiency promotes VHA's continuing commitment to its four missions:

- Education of health professionals;
- Research to advance the care of Veterans;
- Supporting our Nation's emergency preparedness and; above all else
- Providing the best possible care for Veterans.

Question 20: In this budget proposal, VA has created a ranking process specifically for non-recurring maintenance projects, whereas previously they were considered together with the minor construction projects. The stated goal is to give VISN directors more input. What is the intended outcome of this change, and how will doing so enable non-recurring maintenance projects to be selected more accurately or accomplished more quickly?

VA Response: In previous years, the budget development of the Strategic Capital Investment Plan (SCIP) decision criteria model was the same for Non-Recurring Maintenance (NRM), Minor Construction, Leasing, and Major Construction. The SCIP decision criteria model included seven primary criteria and over twenty-two sub-elements. Not all elements of the decision criteria model were applicable to the NRM program; as many of the elements were strategic in nature and could not be accomplished through the NRM program. Through this budget proposal a focused and streamlined decision criteria model was developed specific to the NRM program that included the following three primary criteria: VISN Priority, Facility Condition and Planning priorities.

This newly developed decision criteria model provides a more focused request for NRM projects in 2019 and a prioritized list of NRM initiatives that reflect the top priority of the VISN while also focusing the limited NRM funding on the NRM program goals of addressing VHA's most pressing infrastructure needs. This change removes NRM project prioritization from a compiled list of all strategic initiatives in the Minor Construction, Major Construction, and Leasing programs, which approvals are based upon multiple elements not relevant to NRM projects. Additionally, this change allows for the focused criteria specific to the NRM program.

Question 21: The budget includes two legislative proposals allowing expanded funding transfer authority for joint construction and facilities projects, with the Defense Department and other agencies. A version of this language also appears in VA's proposed CARE legislation. If enacted, how will VA ensure such funds would be spent effectively after they become comingled and the management and execution responsibility, formerly residing in VA, is divided between two agencies?

VA Response: If the VA/DoD proposal is enacted, both Departments will utilize lessons learned from previous experiences, including the operation of the Captain James A. Lovell Federal Health Care Center in North Chicago, to ensure proper management and execution of joint capital projects. Prior to the implementation of the effort, VA will ensure appropriate financial controls are put in place to avoid comingling or inefficient use of funds before any funds are transferred between Departments.

Question 22: The budget request includes $150 million for state extended care matching grants, which is expected to fund 10 grants. How many beds will that produce?

- a. The budget request also includes $190 million to build one, 120-bed community living center in Canandaigua, New York, as well as to renovate three buildings there. Has the Department conducted any formal analysis or cost-benefit study comparing the efficiency of producing community living and extended care beds through state grants compared to VA construction?

VA Response: Canandaigua VA Medical Center does not have a methodology to determine how many State Veterans Home beds would be created by $150 million in extended care matching grants or the locations in which the State Veterans Home beds would be created. Population demographics may suggest greater need for this type of bed expansion in other areas of the country. The budget request is not for the construction of a new community living center (CLC), but is for the replacement of the current facilities. The Canandaigua VAMC current has 116 operating nursing home beds on their campus, with an Average Daily Census for the 1st quarter of FY 2018 of 93.7. Currently, there is no capacity in the Canandaigua community to absorb CLC Veteran Residents at this time, either in the State Veterans Homes or Community Nursing Homes. At this time, the Canandaigua VAMC has contracts with 4 community nursing homes (3 in Rochester, NY, and 1 in Lyons,

NY). As with many VA CLCs, there are Veterans with medical and mental health co-morbidities for whom there are limited to no community options. The Canandaigua VAMC plans to develop this CLC as a niche with the small house model to assist other facilities across the New York region that have Veterans who are difficult to place in the community settings and who are residing in acute care settings. VA is currently rolling out a new initiative, Care of Patients with Complex Problems to assist VAMCs nationwide in establishing systems to optimize care for this difficult population.

The State of New York currently has 5 State Veterans Homes; however, only one is located within a reasonable geographic proximity (Batavia) and, it is the smallest of the 5 state homes. VA stands ready to assist the State of New York if they should wish to pursue the idea of constructing a new State Veterans Home.

Locatin	Number of Beds	Distance from Canandaigua (miles)
Jamaica, NY	250	335
Batavia, NY	126	57
Oxford, NY	242	148
Montrose, NY	252	292
Stoney Brook, NY	350	371

Construction plans and designs for the creation of the replacement CLC environments at Canandaigua are being reviewed through value management efforts conducted by the United States Army Corps of Engineers to determine that the construction is the most cost effective and efficient possible and would be consistent with industry construction standards. The budget request replaces out of date and inefficient existing facilities at Canandaigua to house the Veteran population currently served as well as developing specialized placement options for Veterans with medical and mental health co-morbidities for whom there are limited to no community options. New small house construction will provide state-of-the-art care environments for Veterans. The nearest State Veterans Home to Canandaigua is 57 miles away (Batavia) and would not necessarily facilitate the needs of Veterans that would be placed a great distance from their home and family in the Finger Lakes Market.

It is important to note that the census indicated in the narrative below (first quarter FY 2018) is temporarily restricted to facilitate minor renovations to the existing CLC floors. The admission cap will be removed following the completion of renovations.

Question 23: Please explain the aspects of the President's Infrastructure Initiative that pertain to VA and what impact the Department expects it will have.

VA Response: The President's Infrastructure Initiative includes new and pilot authorities that will provide additional tools for the Department to modernize and obtain upgrades to VA's real property portfolio to support delivery of quality care and services to Veterans. If legislation is enacted, the authorities will provide flexibilities for VA to leverage existing assets to continue its efforts to reduce the number of vacant buildings in its inventory and will make lease threshold modifications to change the lease project amount required to obtain congressional authorization for VA medical leases. This change would streamline VA's leasing process to quickly and efficiently deliver needed facilities to provide care and services to Veterans.

a. Is this budget request sufficient to fulfill the goals of the initiative?

VA Response: Yes, the budget request is sufficient to fulfill the goals on the initiative. The new tools, if legislation is enacted, will allow VA to leverage existing facilities and land to obtain new facilities and space with little upfront investment cost for VA.

b. Does VA believe the initiative provides the authorities needed to ″right size″ and align capital assets and infrastructure, without additional legislation? If not, which authorities would still be needed in legislation?

VA Response: VA is encouraged by the Infrastructure Initiative and believes that legislation authorizing sales and retention of proceeds, exchanges for construction value, and increasing the leasing and construction thresholds will expand the options VA has available to manage its real property portfolio more effectively. In addition to the authorities proposed in the President's infrastructure initiative, the Department needs the proposed authorities included in the FY 2019 Budget submis-

sion to be enacted in order to increase VA's flexibility to meet its capital asset needs, realign facilities, and reduce energy costs, including:

- Amend the medical facility definition to allow VA to plan, design, construct, or lease joint VA/DoD shared medical facilities; and to transfer and receive funds for those purposes.
- Increase to the threshold between major and minor construction - from $10 million to $20 million.
- Authority to expand VA enhanced-use lease authority beyond supportive housing for other mission needs.

Question 24: The budget request includes a status list of leases that were authorized in previous years. Among other information, the list indicates which of these leases have still not been awarded; they are summarized below by year of authorization. When is VA's goal to award each such lease, and how will this be accomplished?

2005: 2

2006: 1

2010: 2

2011: 3

2012: 1

2014: 21

VA Response: The following leases were replaced by subsequent lease authorizations as noted in the FY 2019 budget submission: Norfolk, VA (2005), San Diego, CA (2005), Tyler, TX (2006), Kansas City, KS (2010), and San Diego, CA (2011). Due to lack of availability within the market the Boston, MA (2011) lease has been decreased to a minor level lease of approximately 10,000 sf, with specific services to now be provided through existing infrastructure.

The following leases are moving forward in earnest and currently slated for award in FY 2018 or early FY 2019: Bakersfield, CA (2010), Columbus, GA (2012), Brick, NJ (2014), Cobb County, GA (2014), Charleston, SC (2014), Myrtle Beach, SC (2014), New Port Richey, FL (2014), Ponce, PR (2014), Chattanooga, TN (2014), Houston, TX (2014), Lubbock, TX (2014), San Antonio, TX (2014), Tulsa, OK (2014), Redding, CA (2014), Honolulu, HI (2014), Phoenix, AZ (2014), and San Diego, CA (2014). For these leases, VA is currently evaluating offers and negotiating price to ensure treatment as an operating lease, fair and reasonable pricing, as well as vetting offers to ensure bidders have necessary qualifications and relevant experience to deliver projects of comparable magnitude.

For the following leases, VA was unable to obtain proposals that met OMB Circular A-11 scoring criteria for an operating lease, or experienced other procurement challenges that made these projects candidates for a re-start under VA's improved lease process: Lincoln, NE (2014), Cape Girardeau, MO (2014), Johnson County, KS (2014), Worcester, MA (2014), and Tyler, TX (2014).

Question 25: How does this year's budget proposal prioritize foundational services over other services, and what differences will veterans and employees see next year as a result of this prioritization?

VA Response: It is VA's priority to provide world-class mental health care to all Veterans. To this end, there are a number of new and expanding mental health initiatives that will enhance mental health services. EO 13822, Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life (January 9, 2018) focuses on ensuring that Veterans have seamless access to high-quality mental healthcare and suicide prevention resources, with an emphasis on the 1-year period following separation from active duty. VA is committed to hiring a net gain of 1,000 additional providers to continue expanding suicide prevention efforts, same day services, and treatment options available to Veterans. The Measurement Based Care initiative will make immediate use of Veteran self-reported outcome measures to individualize and improve mental health care. Overall, the budget request will enable the Department to continue established, well-validated mental health programs, as well as offer opportunities for continued expansion of services and access.

a. Will each clinic, medical center, or VISN develop its own foundational services?

VA Response: Every VA medical center already has Primary Care, Geriatrics and Mental Health foundational services established and each service has its own local leadership, reporting to a facility's executive leadership team.

b. Is each facility expected to provide all of VA's foundational services, or will the services vary from place to place?

VA Response: Services will vary depending on the complexity of the facility. All facilities however, will be required to offer Primary Care and Mental Health at a minimum. All facilities are required to provide a spectrum of Geriatrics and Extended Care Services as articulated in the Medical Benefits package.

c. Is inpatient care a ″foundational service?″

VA Response: Inpatient care is in the Medical Benefits Package, but it is not a ″foundational service″ available at every VA medical facility. VA offers hospice and palliative care in all care settings, including in every VA inpatient facility.

d. Given that a significant amount of VA's assets are directed to inpatient care, does the budget proposal contemplate realigning the assets toward that goal by, for example, converting low-census inpatient facilities into outpatient clinics and surgery centers?

VA Response: The budget request does not include realignment of assets. However, as VA enhances its portfolio of home and community based services, we anticipate reducing preventable hospitalizations and nursing home stays which may have an impact on future budget allocations.

e. If inpatient services are reduced, how will this affect VA's educational mission, given that a significant portion of graduate medical education support is for inpatient services?

VA Response: Medical research and graduate medical education (GME) are two of VA's four missions and thus VA will continue to place a high priority on fulfilling those roles. While acknowledging that the focusing of VA resources towards Foundational Services could have effects on medical research and GME activities, those impacts will be mitigated by the national methodology that has to be developed for VISN and VAMC leaders; one of the primary considerations is the potential impact on these programs. In addition, if deemed necessary VA will create partnerships to support its research and education missions to ensure the well-being of Veterans and the Nation as a whole.

f. Will the proposed focus on foundational services direct more inpatient services into the community? If so, will community care funding need to be increased?

VA Response: Well-resourced and well-staffed foundational services optimizing outpatient care and home and community-based services, particularly among high risk patients, should prevent avoidable hospitalizations/inpatient services and nursing home stays. VA facility and VISN leaders are being asked to assess additional, non-VA options for other health services that are important to Veterans, yet may be as effectively or more conveniently delivered by non-VA providers. Local VA leaders have been advised to consider accessibility of VA facilities and convenience factors (like weekend hours), as they develop recommendations for community access to non-VA providers for Veterans in their service areas.

Question 26: During the budget roll-out briefing held on February 12, 2018, at VA headquarters, a Committee staff member was told the budget proposal does not include costs associated with the recent Executive Order to increase access to mental health care and suicide prevention services for transitioning Servicemembers in the year following their separation from service. However, the news release that accompanied the budget stated the budget does support the Executive Order. Please clarify the conflicting information.

VA Response: Shortly before Budget rollout, Congress adopted a bipartisan agreement to raise the FY 2018 and FY 2019 budgetary caps significantly above the current law. Although not reflected in the Budget, the Administration has communicated its preferences for the allocation of these additional resources in FY 2018. In this communication, the Administration outlined a need for $3.2 billion for VA in FY 2018 to support infrastructure improvements, continuation of the Veterans Choice Program, and implementation of the EO over a 2-year period.

Question 27: The budget assumes 162,000 additional mental health outpatient visits. Are these a result of the expanded mental health authorities from the Executive Order?

VA Response: VA estimates as much as $100 million from VA's existing budget will be used to support implementation of EO 13822, by realigning funds to support suicide prevention as one VA's core priorities. Not all of the mental health services

provided to transitioning Servicemembers and Veterans as a result of the EO will be high-cost services.

Question 28: How many of the additional 162,000 projected mental health outpatient visits are the result of the recent initiative to expand mental health care to veterans with Other than Honorable discharges?

VA Response: Assuming the 2017 trends with Other Than Honorable (OTH) emergency mental health services continue, this will be a small portion of the total projected workload.

a. Has the utilization of care by veterans with OTH discharges been as expected?

VA Response: The number of OTH former Servicemembers seeking emergency services has been below expectation. Overall, since July 5, 2017, 4,973 OTH former Servicemembers have requested VHA healthcare through the present, with only a limited number specifically seeking mental health emergency services.

b. Has VA noticed any regional trends in health care utilization by these veterans?

VA Response: There have been relatively few OTH former Servicemembers seeking VA health care services to date. VA is developing evaluation databases that will allow us to examine regional, demographic and clinical trends in this population in the coming months.

c. What types of mental health services are these veterans seeking?

VA Response: Emergency inpatient hospitalization, outpatient services and medication refills.

d. How many of these veterans are eventually deemed eligible to enroll-and, in fact, do enroll-in the VA healthcare system?

VA Response: VA, DoD and the Department of Homeland Security submitted a Joint Action Plan to the White House on March 9, 2018, related to implementation of EO 13822. Additionally information will be provided once the plan is publically released.

e. How successful has VA been in transitioning those veterans who are not eligible to enroll in the VA healthcare system to other care settings?

VA Response: There has been no indication or report of facility inability to transition care as appropriate. All licensed providers have an ethical responsibility to ensure follow-up is established prior to provider-patient termination.

f. How, if at all, has mental health care to honorably discharged veterans been impacted by the Other than Honorable discharge initiative?

VA Response: Direct impact on access and mental health services has been negligible. The largest impact is typically during the initial period of the request for care. Crisis management commonly takes dedicated provider effort over what can be considerable time. Cross coverage during these periods is critical, and sites with staffing limitations would experience the greatest impact.

Question 29: How would this budget proposal fund suicide prevention initiatives with community partners, given that 70 percent of veterans who die by suicide are unknown to VA?

VA Response: Ending Veteran suicide will take a national effort that is community based. Partners, at all levels, are key to those efforts and a major focus of our innovative approach to suicide prevention. Initiatives underway or currently planned include expansion of partnerships specifically targeting services to Veterans not enrolled in VA care, the Mayor's Challenge program building community capacity to end Veteran suicide, and the evolution of our suicide prevention coordinator model from a healthcare and crisis concentrated model to one that also includes public health, community centered approaches.

Question 30: To what factors does VA attribute the 86 percent increase in the number of veterans receiving mental health services from 2005 to 2017?

VA Response: There are likely a number of social and organizational factors that have contributed to the significant increase in the number of Veterans receiving mental health services. Organizationally, over this 12-year period, VHA has made significant investments in hiring and program development. VHA has consistently demonstrated that if facilities invest in hiring and program implementation, Veterans will utilize the services. The challenge that VHA has been experiencing is that

the utilization then outpaced the ability to continue hiring and expanding program availability. Socially, mental health services are more available and culturally accepted. Importantly, the extensive mental health services were not available for returning Vietnam-era Veterans, and in combination with the current war on terrorism, an increasing number of Veterans continue to utilize VHA mental health services.

a. Is a similar increase expected over the next decade? If so, how much more mental health capacity will be needed within VA to accommodate that increase?

VA Response: There is a huge gap in treatment for mental health conditions across the U.S. as a whole. This gap is due to: a lack of access to treatment, barriers to receiving care, social stigma that still, in some parts of the country, attaches to the receipt of mental health services, or a lack of perceived need for services. For example, the 2015 National Survey on Drug Use and Health (NSDUH) estimated that 21.7 million Americans had clinical need for substance use disorder treatment, but only 2.3 million of these received specialty treatment; however, 95 percent of those with identified clinical need for treatment who didn't receive treatment did not perceive a need for care (e.g. see report at: https://www.samhsa.gov/data/sites/default/files/report—2716/ShortReport-2716.html). These population statistics on one mental health condition frame the general problem. Large populations of Americans, including Veterans, have mental health conditions that are not being treated. Lack of treatment almost certainly has negative personal and societal costs and consequences, but these populations are not necessarily actively seeking services. Prior analyses have suggested that Veterans have slightly lower unmet need compared to the general population (see Golub A, Vazan P, Bennett AS, Liberty HJ). There is an unmet need for treatment of substance use disorders and serious psychological distress among Veterans (see the Nationwide analysis using the NSDUH: Mil Med. 2013 Jan; 178(1):107-14.).

VHA added treatment capacity from 2005 to 2017, which allowed some of this population to access needed mental health services. The increase in number of patients treated was driven by budget/mental health service capacity in VHA, not by shift in population need for services. While adding capacity, VHA made changes to its health care delivery design to improve mental health screening and bring mental health services to patients being seen in primary care, helping to address the tendency of persons with mental health conditions to not actively seek care. However, there is still a substantial unmet need. VHA is implementing additional innovations in mental health care delivery, including clinical video telehealth and telephone care management services, which may help to make mental health services more accessible and acceptable to Veterans with clinical need. We expect that increased treatment capacity and availability of standard and innovative mental health care, would continue to increase the proportion of Veterans with mental health conditions who receive treatment. If additional capacity for services is provided, we expect to continue to see an increase in mental health service utilization for some time, as we are not near a steady state in terms of meeting the full need for mental health services.

Question 31: The budget proposal includes five additional Vet Centers by 2020.

a.What data was used to determine that five are needed?

VA Response: The Readjustment Counseling Service (RCS) used workload and productivity data, including growth rate in relationship to capacity to determine resource of the new Vet Centers. Since FY 2016, RCS has seen a 27 percent growth in the number of unique Veterans, active duty Servicemembers, and families served by Vet Centers. During the same period RCS has experienced a 17 percent growth in the volume of readjustment counseling services (individual, group, marriage, family counseling, outreach, etc.) provided. RCS is expected to experience similar growth rates in the next several FYs.

RCS current assets consist of the 300 ″brick and mortar″ Vet Centers, 80 Mobile Vet Centers, and the Vet Center Call Center. Until recently, new Vet Centers were approved and placed into communities based on county Veteran population and proximity to other Vet Centers. This expansion process was changed in 2016 to a demand model taking into account actual Veteran and active duty Servicemember (ADSM) usage and ensuring that services to communities are in line with the needs of those particular communities. This includes having RCS staff regularly provide services beyond the existing 300 Vet Centers through the use of Vet Center Community Access Points (CAPS) and Vet Center Outstations.

- Vet Center CAPS are locations typically in non-cost space located in sites developed in collaboration with community partners where direct counseling services

are provided at levels that are consistent with the needs of these communities (monthly to several times a week). As the demand for services change or moves to other communities, RCS staff are able to move with that demand with minimal effort and cost.

- Vet Center Outstations are leased spaces located in communities where the demand for services requires at least one full time counselor (40 hours per week) to be permanently assigned. Supervision and administrative responsibilities are provided through the closest Vet Center. Vet Center Outstations are developed by RCS and approved by the Under Secretary for Health pursuant to a delegation of authority signed by the Secretary on June 1, 2016.

Typically, RCS staff begin the expansion process by working to understand the demand and needs of a particular community through targeted outreach and the piloting of service provision through a Vet Center CAP. As services progress, Vet Center leadership assess and increase or decrease services based on that actual demand.

If service provision increases to a point that requires a counselor(s) to be in that community permanently, RCS Leadership works to receive approval for a Vet Center Outstation. This approval also allows RCS to explore leasing opportunities for a permanent location in that community

As demand for services at Vet Center Outstations increase and require more resources such as additional staff and space, RCS Leadership will work to receive approval to create a full ″brick and mortar″ Vet Center.

b.When are each of the five scheduled to open?

VA Response: The five new Vet Centers are scheduled to open beginning in FY 2019 through the end of FY 2020. At the current rate of growth (both services provided and associated with unique Veterans, ADSM, and their families) and current Full Time Equivalents (FTE) employee levels, continued growth in services will be significantly limited in approximately 2 years. RCS is working to create additional efficiencies to deal with potential capacity issues through decreasing time to hire through a centralized human resource service, authorized FTEs increases, and increasing the number of CAPS to reach underserved areas. This also includes reviewing the current footprint of Vet Center Outstations to assess and determine if any of these locations need to be converted to a full ″brick and mortar″ Vet Center.

c.Where will they be located?

VA Response: The locations will be determined utilizing the demand model outlined above.

d.What impact will the five additional Vet Centers have on mental health access?

VA Response: Additional Vet Center locations will positively affect the VA's overall ability to increase access to care for eligible Veterans, active duty Servicemembers, and their families while decrease barriers associate with accessing that care (ex: driving distance). The RCS strategic goals for 2018-2020 include improving access to Readjustment counseling in communities distant from existing Vet Center services by increasing the number of Vet Centers (projected increase of five), Outstations (projected increase of five), and Community Access Points in Rural and Highly Rural Areas. In addition, RCS is increasing non-traditional hours of service provision, coordinated emergency response capability, and expanding community partnerships. All RCS service provision is legislated through 38 U.S.C. Section 1712A. RCS, by design, is a non-medical service provided without the need of a diagnosis or enrollment in VHA healthcare. RCS staff work collaboratively with local VHA staff to engage Veterans, Servicemembers and their families and to facilitate obtaining appropriate medical care, including more intensive mental health services. RCS has historically proven to be a very effective entry point into the larger VA, especially with Veterans, Servicemembers and families that might be reticent to enter into mental health treatment given stigma and all other barriers to care.

Question 32: If enacted, how will this budget proposal improve the timeliness of medical health care services that veterans experience, and how will timeliness be measured?

VA Response: This proposed funding would support staffing requirements needed to optimize access where patient demand exceeds staff supply with a particular focus on primary care, mental health, and medical and surgical specialties. Such staffing would include nursing and administrative clinic staff in addition to providers. The funding would also support optimizing recruitment and retention incentives for specialties and parts of the country where staffing has been challenging

to optimize. Furthermore, this proposed funding would support the expected rapid increase in virtual care services such as telehealth. Timeliness would be measured by average wait times to see new and established patients that will be publicly displayed on the www.accesstocare.gov website.

Question 33: How will initiatives funded in this budget proposal reduce the Electronic Wait List?

a.How many unique veteran patients are on the Electronic Wait List as of the date of VA's response to these questions?

VA Response: Presently, there are over 15,960 Electronic Wait List Veteran entries comprising 15,408 unique Veterans (i.e., some Veterans may be listed on the Electronic Wait List for more than one appointment type).

b.How many are forecasted to be on the list a year from that date?

VA Response: With the added funding proposed to expand Veteran access to medical care, it is projected that in 2019, the number of Electronic Wait List entries will decline by approximately 33 percent to 10,653.

As mentioned in the response to question 32, the proposed funding would support staffing needs to optimize access where patient demand exceeds staff supply with a particular focus on primary care, mental health, and medical and surgical specialties. This staffing would include nursing and administrative clinic staff in addition to providers. Such funding would also support optimizing recruitment and retention incentives for specialties and parts of the country where staffing has been challenging to optimize. Furthermore, this proposed funding would support the expected rapid increase in virtual care services such as telehealth. All of these efforts would be expected to reduce the Electronic Wait List.

Question 34: What is the current utilization rate for same-day services for primary care and for mental health care?

a.How many veterans seeking same-day access to primary and mental health care currently receive an in-person or telehealth appointment that same day?

VA Response: In Mental Health, 11.1 percent of all face to face and telehealth appointments combined were completed the same day in FY 2017; 11.3 percent of all face to face and telehealth appointments combined were completed the same day during the first quarter of FY 2018.

In Primary Care, 20.5 percent of all face to face and telehealth appointments combined were completed the same day in FY 2017; 23.7 percent of all face to face and telehealth appointments combined were completed the same day during the first quarter of FY 2018.

In Mental Health during FY 2017, 773,235 appointments were completed the same day via face to face appointment where 23,007 appointments were completed the same day via telehealth during FY 2017.

In Primary Care during FY 2017, 2,453,882 appointments were completed the same day via face to face appointment where 3,860 appointments were completed the same day via telehealth during FY 2017.

VA also may provide same day services via telephone encounters and secure email messages. VA is unable to currently measure how many Veterans receive same day services via these care modalities.

Question 35: The budget indicates VA expects to treat 80 percent of enrolled veterans who need Hepatitis C care with new Hepatitis C treatments by 2020. What barriers to care exist for the remaining 20 percent of enrolled veterans with Hepatitis C?

VA Response: Consistent with Centers for Disease Control and Prevention and United States Preventive Services Task Force recommendations, VA recommends screening of all patients born between 1945-1965 for Hepatitis C virus (HCV) as well as those who have on-going risk factors for HCV infection. As of March 30, 2018, 82.5 percent of all high-risk patients have been tested for HCV. VA continues to do outreach to offer testing to patients at risk for HCV

As of April 30, 2018, over 107,719 Veterans under VA care for their HCV have been started on new, highly effective antiviral treatments, with cure rates of 95 percent. It is estimated that there are approximately 31,644 Veterans under our care for HCV who remain to be treated with these new treatments. We estimate that approximately 9,000 of these remaining patients will receive treatment in FY 2018. VA has made documented efforts to contact most, if not all, of the 31,644 Veterans with HCV who remain to be treated. Many have not responded or have otherwise refused treatment, are homeless, or have medical, mental health, or substance use

comorbidities which are treatment limiting. For those in this untreated subset who wish to receive HCV treatment, it will be provided in FY 2019, assuming they do not decline treatment, fail to follow-up with their treatment plan, or have clinical contra-indications (such as unstable/uncontrolled/incurable co-morbidities) preventing such treatment.

Current program outreach efforts include the use of: Field-based VISN Hepatitis Innovation Teams deploying system redesign/LEAN at the majority of facilities to address gaps in HCV testing and treatment; informatics tools for patient tracking and monitoring clinical outcomes (HCV Clinical Case Registries/HCV clinical dashboards); national and local social media and advertising campaigns; patient and provider resources; and local outreach and prevention programs targeted for high-risk populations.

Question 36: How much money does VA anticipate spending in fiscal year 2019 on gender-specific services for male veterans?

VA Response: Gender-specific services for male Veterans include a variety of clinical services including Urology, Pharmacy, Prosthetics, and other services. VA does not have any specific data point to anticipate spending for gender-specific services for male Veterans.

Question 37: Written testimony indicated VA has ″.critically assessed and prioritized our needs and aggressively pursued internal offsets, modernization reforms, and other efficiencies.″ Please provide a copy of that assessment.

VA Response: As part of the Department's budget formulation process, the Administrations and staff offices assessed and prioritized needs and internal offsets and modernization reforms to focus resources for high priority functions or initiatives. Some examples of internal offsets and modernization reforms that are built into the FY 2019 Budget include VBA's repurposing of personnel from indirect support activities to Veteran-facing functions, reductions in VBA contracts, modernization of the EHR and Financial Management System, prioritization of foundational services while redirecting to the private sector those service that they can do more effectively and efficiently, and $30 billion in VBA administrative savings over 10 years.

Question 38: How does this budget represent a new prioritization of needs compared to prior budgets?

VA Response: This budget targets key areas in which we want to make significant improvements. Examples include full discretionary funding for Veterans Community Care starting in FY 2019; a significant investment for Capital Investment; new funding for the EHRM effort; and targeted resources for disability claim appeals, women's health and mental health to include suicide prevention which are all high priorities for the Administration.

Question 39: Please explain how the portion of the budget pertaining to the Financial Management Business Transformation relates to the Administration's proposal for a VA Center for Innovation for Care and Payment.

VA Response: The proposed VA Center for Innovation for Care and Payment would carry out pilot programs to develop innovative approaches for testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by the Department. FMBT would support this effort by providing a comprehensive financial management system that enables VA to accurately measure progress from a financial aspect while complying with financial management legislation and directives.

Question 40: Would the Working Capital Fund legislative proposal allow VA to become a shared service provider for financial management systems modernization?

VA Response: While VA is already an internal shared service provider for financial management system modernization through its FMBT program, the Working Capital Fund (WCF) legislation will certainly strengthen and enhance the FMBT program. WCF legislation was proposed so that VA can finance critical financial management activities such as FMBT and the Stop Fraud, Waste, and Abuse initiative to improve payment integrity. Long term, the WCF legislation will support VA's centralization of financial services and eliminate costly redundancies.

Question 41: Why are medical care collections expected to decrease in fiscal year 2018 and 2019, compared to 2017?

VA Response: FY 2018 and FY 2019 medical care collections incorporate the full impact of the Tiered Medication Copayment Structure of $5 for preferred generics/

$11 for brand single source/ $8 for all other medications, and a $700 copayment cap for all priority groups. The tiered copayments and copayment cap, combined with the impact of Pharmacy utilization trends, resulting in lower First Party collections in FY 2018 and FY 2019.

Third Party payers are terminating and/or reducing reimbursement to VA for non-service-connected care. Payers are reacting to current market conditions in commercial health care by attempting to reduce provider reimbursement rates across the board. To account for these payer trends, it's anticipated that collection estimates will continue to decline in FY 2018 and stabilize in FY 2019. MCCF estimates include an adjustment for the projected budget impact of changes to payer agreements. The estimated impact of the changes in reimbursement rates are reductions in potential Third Party collections of $119M in FY 2018 and $124M in FY 2019.

Question 42: Is it correct that VA's average Medical Care Collections Fund collection rate is based on billings, not another basis as commonly stated, is roughly 36.5 percent?

VA Response: VA has historically reported collections performance/efficiency using the Collections to Billing (CtB) ratio, which compares claim level collections to gross billed amounts. The CtB ratio did not account for the limitations based on payer maximum allowable charges or patient cost sharing responsibilities which are uncollectible by the VA. In other words, the billed charge reflected amounts that VA would never have collected from a veteran's private health insurance plan (for example, because VA had conducted a rate verification with the insurance company and verified a reimbursement rate that is lower than billed charges but consistent with what the payer is reimbursing other providers).

To more accurately reflect VA's collections performance/efficiency, VA will report collections performance using Net Collections Ratio, which is a VA-developed measurement that is comparable to industry standard reporting on collection performance and provides a more accurate representation of VA's effectiveness in optimizing collections from 3rd party payers. Net Collection Ratio measures collections as a percentage of Total Collectible Amount instead of billed charges. The Total Collectible Amount is billed charges minus uncollectible amounts like payer discounts that VA has negotiated and other health insurance (OHI) patient responsibility (e.g., copayments and co-insurance, which VA does not collect). The national Net Collections Ratio as of February 2018, is 95.9 percent, which is in-line with industry trends of 95% to 100% of net collectible revenue.

a.How would initiatives in the budget proposal improve VA's ability to collect, and what is the expected collections rate, in percentage terms as well as dollars, after they are implemented?

VA Response: VA included five legislative proposals in the FY 2019 President's Budget that are intended to improve the efficiency and effectiveness of revenue operations. For all of the legislative proposals, the net collections ratio would remain stable.

1.Acceptance of VA as a Participating Provider by Third Party Payers would allow VA to be treated as a participating provider for reimbursement purposes whether or not an agreement is in place with a third party payer of health plan. If enacted, this legislative proposal will provide VA with the ability to collect at the participating provider reimbursement level. Currently, when VA provides services for a Veteran who has coverage under a third party payer who does not have an agreement with VA the out of network reimbursement is reduced or may be non-existent if the third party payer does not offer out of network benefits. The anticipated increase in collections is $105.9M annually.

2.Aligning with Industry Standards by Eliminating Offsets of First Party Copayments would allow VA to discontinue the practice of crediting the first party copayment due from Veterans for non-service-connected care using the funds collected from third party health plan carriers. The legislative proposal would align VA with private sector practices. The anticipated increase in collections is $53.9M annually.

3.Mandatory Insurance Capture Enforcement would create a mechanism to enforce the disclosure of third party health plan contract information as required by Public Law (P.L.) 114-315, section 604. This legislative proposal creates a mechanism for Veterans who fail to provide third party health plan coverage information necessary to VA for the purpose of billing and collecting from third party payers. The anticipated increase in collections is $8.5M annually.

4.Improving Timeliness of Billing by Authorizing the Release of Protected Patient Information for Health Care Services would allow VA to disclose records of the iden-

tity, diagnosis, prognosis or treatment of a patient relating to drug use, alcoholism or alcohol abuse, infection with human immunodeficiency virus or sickle cell anemia to health plans for the purpose of reimbursement. Currently, VA is required to obtained a signed release of information from the patient before billing a claim for these services to a third party payer. This legislative proposal would bring VA in line with private sector practices and allow VA to submit claims for reimbursement without obtaining a written authorization from the Veteran. The anticipated increase in collections is $42.4M annually.

5.Third Party Payer Enforcement Provision (Recover Lost Collections from Third Party Payer) provides a provision that will allow VA to institute administrative enforcement actions against third party payers who fail to comply with provisions of 38 USC 1729 and supporting regulations 38 CFR 17.101 and 38 CFR 17.106. Any funds collected through the administrative enforcement actions would be additional revenue returned to MCCF to provide additional services to Veterans across the Nation. The proposed legislation would allow VA to assess fines against third party payers for non-compliance with statutory and regulatory collection provisions. There is no anticipated increase in MCCF collections in FY 2019 until regulatory authority is in place.

Question 43: What is VA's official position on using third party collections entities to assist the Department in collecting revenues?

VA Response: Generally, VA can use third party collection contractors provided that it is not subject to transfer to Treasury, when it is in the government's financial interest, and it is consistent with the purposes of the Debt Collection Improvement Act of 1996 (DCIA) (31 CFR 285.12). In addition, VA has a separate authority under 38 U.S.C. § 1703 to award a contract to a third party collection entity to audit VA community care claims and payments and to initiate recovery of any overpayments.

Question 44: How many of the research projects that would be funded in this budget proposal involve canine test subjects?

VA Response: Based upon historical trends, 1-3 new research projects funded annually by VA would typically involve the use of research dogs. Continuing support of 7 existing VA-funded dog projects is anticipated as well.

Question 45: How does VA evaluate proposed research projects to ensure they are veteran-centered and veteran-focused?

VA Response: The VA Office of Research and Development (ORD) conducts scientific peer review to the highest standards similar to other science funding agencies and funding decisions are awarded based on their ability to meet our Service Mission and priorities for Veterans health care needs. In order to be reviewed, an application must align with one of the ORD Research Services scientific purview and advance scientific knowledge across the research continuum including biomedical, clinical, health services, and rehabilitative research. The review criterion is explicit in that research must address an important scientific question and supports and advances the health and health care of Veterans. Specifically, a proposed research project must meet the following criteria to clearly demonstrate it has significant impact:

- Significance - addresses important problem or critical knowledge gap in the field; supports or advances the health and health care of Veterans.
- Innovation - challenges existing paradigms, explores new concepts, methodologies, or technologies.
- Approach - incorporates current scientific and theoretical bases; hypothesis-driven; use of appropriate research design and methods for addressing hypothesis; feasibility of methods are clear.
- Investigators - utilizes investigators with appropriate expertise, experience, and record of accomplishments to enable successful completion of the proposed research.
- Resources - proposed research environment will enable successful project (e.g., facilities, equipment, and staff).After scientific merit review, final funding decisions are made by ORD's Service Directors based on impact or priority scores, peer reviewer evaluations, ORD priority areas, and available budget.

a.Are there some areas of VA research that could be scaled back or discontinued to make funds available for more veteran-centric research projects?

VA Response: No. ORD only supports projects that are veteran-centric funded.

Question 46: The budget proposal notes that VA research has a track record of transforming VA health care by bringing new evidence based treatments and technologies into everyday clinical care. Please provide 10 examples of VA research conducted in the last five years that directly produced treatments that VA providers are presently using to treat veterans.

VA Response: The following are key examples of evidence-based treatments that are currently being implemented in everyday VA clinical care that were based on VA-sponsored research published within the past 5 years. Links to the original research articles are also provided.

1. Providers in VISNs 7, 16, 20, and 23 are deploying Telemedicine Outreach for Posttraumatic Stress Disorder (PTSD), which is a program based on research conducted in the VA that demonstrated the effectiveness of virtual team-based care for rural Veterans with PTSD: https://www.ncbi.nlm.nih.gov/pubmed/25409287.

2. Providers at the West Haven, Denver, and Palo Alto VAMCs are implementing stepped care for pain treatment, based on a model previously shown to be effective in pain management for Veterans: https://www.ncbi.nlm.nih.gov/pubmed/25751701.

3. Providers in VISN 1, VISN 5 and VISN 19 were trained in the HUD-Veterans Affairs Supportive Housing and Homeless Patient Aligned Care Team staff on Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) Model. MISSION is an evidence-based Veteran-centric intervention developed within the VA and delivered by case managers and peer specialist to address mental health, substance use, and homelessness: https://www.ncbi.nlm.nih.gov/pubmed/26018048.

4. Providers at VA Boston and West Haven are implementing the VA National Bipolar Disorders Telehealth Program: (https://www.ncbi.nlm.nih.gov/pubmed/28665773) which is based on a collaborative care model developed by VA researchers that was shown to improve health outcomes among individual with bipolar and other mental disorders: https://www.ncbi.nlm.nih.gov/pubmed/27780336.

5.VA has hired onto clinical teams over 1,100 mental health Peer Specialists (Veterans with mental illness who are trained to use their experience to help other Veterans with mental illness). This Peer Specialist model has been found to increase patient activation (https://www.ncbi.nlm.nih.gov/pubmed/23657754) and are valued by Veteran patients and VA providers (https://www.ncbi.nlm.nih.gov/pubmed/24091610).

6.Providers at the VA Greater Los Angeles Healthcare System are also implementing an integrated care program previously established in VA research to improve mental health quality and outcomes among women Veterans with anxiety and depression treatment needs. This is an example of a larger program (Primary Care-Mental Health Integration) that was nationally implemented in VA and based on VA research on effectiveness of collaborative care for depression, PTSD, and substance use risk management in primary care: https://www.ncbi.nlm.nih.gov/pubmed/20695668.

7.The Hospital-to-Home campaign initiative was implemented by providers and based on prior VA research (https:// www.ncbi.nlm.nih.gov/ pubmed/ ?term=hospital+to+home +heidenreich +veterans+randomized) and resulted in a decline in 30-day readmission rates and reduction of 21,000 hospital days each year, which translates to cost savings of approximately $18 million per year.

8.In partnership with leaders from the VA National Center for Health Promotion and Disease Prevention, VA providers across the US are implementing the updated VA MOVE! weight management program guidance based on work by investigators at the Durham and Ann Arbor VAMCs: https://www.ncbi.nlm.nih.gov/pubmed/28747191 and https://www.ncbi.nlm.nih.gov/pubmed/25217098.

9.Providing the most advanced upper extremity prosthetic arm to Veterans with limb loss. ORD was the clinical partner in Defense Advanced Research Projects Administration's (DARPA) Revolutionizing Prosthetics program. The industry partner under contract to DARPA was Dean Kamen (DEKA) Research and Development Corporation. ORD conducted optimization and take home-home trials of the DEKA arm (now known as LUKE arm). This led to research data for the Food and Drug Administration (FDA) submission and eventual approval by FDA in 2014, and ultimately led to commercialization of the LUKE arm by MOBIUS bionics for Veterans and the Nation. Two Veterans each received a LUKE arm in June 2017. An historical note of significance is that upper extremity prosthetics had not seen major improvements in over 50 years.

10.Increase in Employment for Veterans with Spinal Cord Injury (SCI). Return to work rates are very low following an SCI for the general population and even more so for the Veteran population. ORD investigators conducted research to develop and test a program intended to get Veterans back into working status. The Spinal Cord Injury Vocational Integration Program (SCI-VIP) was developed with some core principles in mind such as vocational training early on in the overall rehabilitation process, deploy a highly integrated team approach, including vocational services, transportation services, training and adaptations to conduct work. Following research to develop and test SCI-VIP, a Predictive Model Over Time for Employment (PrOMOTE) study was conducted. It was found that the SCI-VIP/PrOMOTE program was effective in helping Veterans with SCI get jobs and stay employed (43 percent). After the research ended, six of the seven study sites continued to offer the program in their clinics, enabling Veterans with SCI to receive training and obtain gainful employment. The investigator is reaching out to others in VHA to describe the program and its successes.

Question 47: The budget proposal includes a 2018-2020 goal of ″achiev[ing] efficiencies and alignment through deployment of strategic field-based councils, including integration with other foundational services, in support of VHA modernization and the agency's priorities.″ What are the ″strategic field-based councils?″

a.Which professionals make up these councils, and what functions are the councils expected to perform?

b.How will these councils achieve increased efficiency and alignment, and how will that increase be measured?

VA Response: The creation of the strategic field based councils is in the concept planning phase. Strategic field based councils could meet several objectives which are currently in design but include improving change management and selection of and prioritization of new initiatives.

Question 48: Another 2018-2020 goal is ″expand[ing] access by opening telehealth capacity for underproductive providers to assist access-challenged providers.″ How does VA define and identify an ″underproductive provider″ and an ″access-challenged provider″?

a.How will ″underproductive providers″ be leveraged to assist ″access-challenged providers,″ and how will such assistance be measured?

b.How will this assistance increase access to care for veteran patients, and how will increased access be measured?

VA Response: VA's goal to expand access using this methodology defines an ″underproductive provider″ in primary care as a provider whose patient panel size, i.e., the number of patients enrolled for care with a given provider, is less than 80 percent of their goal for patient panel size. In mental health, an ″underproductive provider″ is defined as a provider whose individualized productivity is less than 80 percent of their productivity target. An ″access-challenged provider″ would just be the opposite, i.e. a provider who exceeds their patient panel size goal in primary care or exceeds their productivity goal in mental health; this type of provider can be challenged to meet the needs of all the patients they are assigned to serve. VA will be using ″underproductive providers″ to support patient needs via telehealth (or sometimes via traditional face to face appointments) to support ″access-challenged providers″ and areas where there is a shortage of providers. This endeavor will increase access by adding clinic appointments at locations that would benefit from support of additional providers. For example: VA may be experiencing longer than average wait times at one location, but an ″underproductive provider″ at another location could see the patients waiting for care via telehealth and help reduce wait times. This assistance will be measured by assessing for increased panel sizes for the underproductive primary care providers and increased productivity for the underproductive mental health providers. Additionally, the sites that are being supported by this program should experience a decrease in wait times.

Question 49: Another 2018-2020 goal is ″opening a third Veterans Crisis Line location to meet increased demands for crisis intervention services.″ Where and when will the third location be opened?

VA Response: The third Veterans Crisis Line Call Center is located in Topeka, KS on the campus of the Eastern Kansas Health Care System. While it opened in early January 2018, a public grand opening/ribbon cutting ceremony occurred on May 25, 2018.

a.Will the third crisis line location be a stand-alone facility or co-located with another facility or service?

VA Response: The third location is co-located on the campus of the Eastern Kansas Health Care System in Topeka, KS in Building 3.

b.What is the third Veterans Crisis Line location's estimated cost?

VA Response: The estimated first-year start-up cost, including the costs for building renovation, staffing, training, and travel, is roughly $28.5 million.

c.How many more FTEs will be needed to properly staff the third crisis line location?

VA Response: With 57 responders, supervisors, and support staff already on board, there are 82 FTE positions that remain open. However, because of space constraints and pending construction, recruitment will pause at 90 FTE, with a target date of July 31, 2018. Recruitment for these positions is ongoing.

Question 50: How is demand for crisis intervention services measured?

VA Response: The Veterans Crisis Line (VCL) program assesses and measures its effectiveness in accordance with quality of care criteria and standards applicable to other, similar, non-VA crisis call centers by the American Association of Suicidology and the Commission on Accreditation of Rehabilitation Facilities. The program also incorporates measures recommended by VA's Office of Inspector General in its report Office of Inspector General Report No. 14-03540-123, Healthcare Inspection: Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York, February 11, 2016 and Office of Inspector General Report No. 16-03985-181, Healthcare Inspection: Evaluation of the Veterans Health Administration Veterans Crisis Line, March 20, 2017.

More specifically, outcome measures used in the VCL program include key performance variables such as average speed to answer, customer satisfaction, call monitoring, and infrastructure reliability. Across these measures, the following data is relevant:

- VCL answers calls in less than 10 seconds.
- Over 99 percent of calls monitored for quality assurance meet established criteria for ensuring safety.
- VCL currently has an average rollover rate <1.0 percent and an average abandonment rate <5.0 percent.
- Customer Satisfaction is over 95 percent for Veteran and third party callers.
- Substantiated complaints about VCL service are received for less than .001 percent of all calls answered.
- All VCL service modalities (phone, online chat, text) are tested 3 times per day, around the clock.

a.How much increased demand for these services is anticipated within the next two years?

VA Response: Demand for VCL services may change based on factors such as business operation improvements, advertising, and national suicide prevention events and efforts. Based on call patterns of the last year, demand for VCL services is anticipated to increase at an annual approximated rate of 12 percent.

b.How, if at all, does an increased demand for crisis intervention services correlate with expected suicide rates, and how would a demand increase impact veteran suicide rates?

VA Response: There are no industry-established criteria to assess the rate of suicide attempts and completions in direct correlation with crisis call center services or crisis call center effectiveness. Those outcomes are affected by many other variables. VA is committed to do all it can.

- The rate of suicide attempts and completions is critically important. It is best seen as an index of population health management across a health care system including the broad continuum of care including crisis intervention services, mental health care, and other healthcare services (primary care, pain management, etc).
- Combatting Veteran suicide requires continued attention to increased population coverage (access to care), improved continuity of care, and enhanced experience of care (satisfaction) across the entire VHA enterprise. This is why VHA measures and reports on population coverage, continuity of care, and experience

of care as domains within the mental health Strategic Analytics for Improvement and Learning (SAIL) domain as applied to each facility.

Question 51: The budget proposal includes an Annual Performance Plan for VHA. One of the targets for ″Progress in Cerner project implementation (percent milestones met)″ is shown as ″to be determined.″ What will this target be?

a.Other performance targets on the Annual Performance Plan appear low and seem to reflect modest expectations. The overall rating for hospitals is 66.5 percent, for primary care providers is 70 percent, and for specialty care providers 67.5 percent. How are these indicators measured and how were they developed?

VA Response: These indicators are derived from the Overall Provider Rating items in the Consumer Assessment of Health Providers and Systems (CAHPS) surveys that are administered to Veterans who use our hospital, primary care, and specialty care services. CAHPS is the industry standard questionnaire for assessing hospitals, health plans (e.g., Medicare Advantage Plans), and clinician group practices. The item is scored as the percentage of patients giving their provider a score of 9 or 10 on a scale of 1 to 10, where 10 represents ″best care imaginable.″ The targets therefore represent high expectations. The stated rate of increase - an overall of 1 percentage point per year - is commensurate with that seen in Medicare fee-for-service hospitals over the past several years under Value Based Purchasing, which provides financial incentives to private hospitals to improve their performance on this indicator.

On May 17, 2018, the Department of Veterans Affairs (VA) awarded the ten-year, multi-billion dollar Indefinite Delivery/Indefinite Quantity (ID/IQ) Electronic Health Record contract to Cerner. VA awarded the first three task orders under the ID/IQ which include project management, Initial Operating Capability (IOC) site assessments, and data hosting. At this time, VA continues to work with Cerner to identify and develop milestones for the implementation of the new Electronic Health Record. Upon, issuance of these task orders, VA will update the Annual Plan. Our primary milestone at this juncture is Initial Operating Capability 18 months from Oct. 1, 2018. The development of our integrated master schedules and implementation timelines are ongoing, and are due to VA from Cerner for by the end of September 2018. The Office of the Electronic Health Record Modernization is implementing the project and reporting to the Secretary in the absence of a Deputy Secretary.

Question 52: Does VA intend to utilize a third-party auditor employing analytics software, similar to that used by the Centers for Medicare and Medicaid Services, to detect fraud by community care providers, distinct from the existing recovery cost audit? If so, what are the estimated costs of this effort?

VA Response: VA is exploring multiple options in our efforts to combat fraud, waste and abuse. One new initiative is a partnership with Centers for Medicare and Medicaid Services (CMS) to share tools, techniques, and best practices related to combating fraud, waste and abuse. One CMS best practice we are researching is the CMS' contract with their Unified Program Integrity Contractors (UPIC) that use their own data analytics tools, in addition to the CMS provided analytics, to detect and prevent questionable charges. The VA/CMS partnership is not yet mature enough to for VA to make a determination on engaging third party auditors, such as the UPICs.

Question 53: If the requested additional 605 claims processing FTEs are granted, how long will it take to resolve the current claims backlog?

VA Response: The increase of 605 FTE is for VBA's implementation of appeals modernization, with the specific goals of resolving legacy appeals and timely processing decision reviews in the new system. Allocation of the FTE will be entirely to VBA's Appeals Management Office for purposes of accomplishing these goals. Current modeling indicates the legacy appeals inventory could be resolved in approximately 4-6 years based on current trends, assumptions and goals.

While it is anticipated that in FY 2019 VA will be authorized to hire an additional 605 FTEs toward these goals, the Appeals Management Office is maintaining a model to project the needed disposition of existing FTEs during the Rapid Appeals Modernization Program (RAMP) and after implementation of the new system, in order to most efficiently handle both the legacy appeals inventory and new framework decision reviews. During the RAMP program, VA will gather data and conduct trends analyses on aspects of Veterans' behavior, to include their decision to opt-in to the new system, employee productivity, processing timeliness, and inventory measures. Moreover, the model will account for varying RAMP opt-in rates and will help delineate the upper and lower bounds of the resource requirements to work

both RAMP claims and reduce the legacy inventory. As actual data is available and analyzed, a more accurate prediction of capacity needs can be formed to make needed adjustments both during RAMP and into actual implementation to create efficient claims processes.

Question 54: Has VA considered reassigning some employees who have been working on processing of new claims to processing of appeals? If so, how many?

VA Response: VA is continually re-assessing the best use of its limited resources, but at this time, VA does not intend to reassign any additional claims processing employees to appeals. While VA remains committed to addressing the pending inventory of legacy appeals, it must balance that commitment with the need to timely process new claims. As part of balancing limited resources, in early FY 2017, VBA realigned its appeals policy, and oversight of its national appeals operations, under a single office, the Appeals Management Office (AMO). Following this realignment, AMO provided guidance that appeals teams must work exclusively on appeals and cannot be used to perform non-appeals tasks such as processing new claims. This improved focus, prioritization, and oversight helped VBA increase its FY 2017 appeals production by 24 percent. Moreover, during this time VBA processed approximately 1.4 million claims.

Question 55: The budget proposal includes about $175 million for the Board of Veterans' Appeals, which is an increase of $19.2 million over last year's budget request. Please explain why the Board requires this increase, and how the Board will use this increase to address the 162,000 appeals currently pending before it.

VA Response: Currently, there are approximately 158,000 appeals pending at the Board. Of those appeals, approximately 84,000 have not been activated by the Board and are eligible to participate in RAMP. The 2019 request of $174.75 million for the Board is $19.15 million above the 2018 Budget and will sustain the 1,025 FTEs. These employees have already yielded positive outcomes for Veterans since FY 2017. Specifically, the Board is currently on pace to produce over 81,000 decisions, which is an historic level of production.

Question 56: What lessons have been learned in setting up the Office of Accountability and Whistleblower Protection, and what conversations have taken place with other Cabinet secretaries about the need to expand this type of civil service reform government-wide?

VA Response: The Office of Accountability and Whistleblower Protection (OAWP) has learned several lessons while implementing this Act. On June 30, 2018, OAWP submitted its first annual report Congress which includes lessons learned and discusses processes. Of significant note is that OWAP found that their model for structure and mission is unique within the Federal Sector. The implementation required constant re-assessment to successfully integrate the existing tools and skills found with VA's current organization. OAWP has forced VA to change ″business as usual″ which always brings about a natural resistance; however, this discomfort is necessary for VA to achieve the transformation that the legislation requires. VA has documented our steps and lessons learned during this effort to not only provide transparency, but also to produce an efficient and data driven organization that can be replicated across the Federal government should the requirements of the Accountability Act be mandated of other Federal Agencies.

Question 57: The budget request flat-lines the estimated number of vocational rehabilitation counselors at 1,442, the same number for the last three years. The budget also recognizes that there will be a 12 percent increase in participants from fiscal year 2018 to 2019, increasing the ratio of veterans to counselors. How will a static number of counselors handle the increasing demand without degrading the program?

VA Response: Our budget projection of Vocational Rehabilitation and Employment (VR&E) participants, which is based on historical use and projected compensation claims from FY 2018 to FY 2019 (reflected in the FY 2019 President's Budget) is 144,661 to 149,747 (centerline); a 3.5 percent increase. While we expect continued future VR&E participant growth, we will continue to balance workload by achieving positive outcomes, reducing oldest cases (over 10 years), and using technology to enable our counselors.

Question 58: FTEs processing education, vocational rehabilitation, and home loan benefits continue to be flat-lined, or nearly flat-lined, despite significant increases in the volume of claims in all three business lines. What measures is VA taking to prevent increased processing times from resulting?

VA Response: Education Service continues to utilize overtime to address higher than usual processing times during peak workload periods. In addition, Education Service continues to leverage resources from other Regional Processing Offices (RPOs) through brokering in order to process claims and provide the best possible service to our claimants while minimizing delays in receiving benefits. In support of implementing the Forever GI Bill, Education Service is hiring 202 temporary FTEs. A portion of these FTEs will assist with the specialized work related to the Edith Nourse Rogers STEM Scholarship (Section 111), Restoration of Entitlement for School Closure (Section 109) and the Vet Tech Pilot (Section 116), and support processing additional claims because of changes in Forever GI Bill. VA expects to maintain some number of these FTEs through FY 2019, and will perform an initial assessment in December 2018. This preliminary assessment will take into account workload associated with the Forever GI Bill, what the FTE needs are, and whether or not the FTEs should remain temporary, convert to a permanent status, or a mixture of both.

VR&E remains committed to continue working with the Office of Information and Technology on the development and implementation of a new VR&E Case Management System (CMS). The implementation of a new CMS will serve to increase the overall efficiency of VR&E counselors, helping us to transform to a digital and paperless environment. VR&E continues to utilize National Service Contracts to provide counseling augmenting services to VR&E counselors. In FY 2017, VR&E obligated nearly $3.5 Million for these contract services, in direct support of the VR&E program. For FY 2017, VR&E executed over 78 percent of our authorized allocation for these contract services in support of our vocational rehabilitation counselors. To date in FY 2018, VR&E is near or at the established standard of 45 days to process a claim and make an entitlement determination for Veterans applying to the VR&E program.

The VA Home Loan program has experienced a tremendous volume growth over the last 5 years, while staffing levels remained the same. In order to create efficiencies, VA took a major step in creating an electronic loan file review process as well as developing a national work queue for major processes and procedures in the housing program. This has helped the organization manage stakeholders, by receiving and analyzing data from each of those reviews. The VA Home Loan program will continue this effort in the coming years through modernization with the VALERI-R initiative. Through advanced data analysis and reporting, VALERI-R will provide improved oversight and transparency of lender and servicer performance, as well as improved efficiency in benefit delivery. This will enable Veterans to better evaluate loan options and statuses while VA addresses high-risk programmatic challenges with data driven solutions.

Question 59: Does the budget proposal fully support implementation of the Forever GI Bill, to include necessary IT improvements?

VA Response: VA does not foresee any delays in its implementation efforts for Forever GI Bill, and regularly reviews and updates its established project management schedule to highlight and mitigate any potential lapses. With the expected implementation of the most critical Forever GI Bill provisions through an IT solution - Sections 107 and 501 - VA hired 202 temporary FTEs in May 2018 to accommodate any increase in claims processing and the administration of new programs associated with the Forever GI Bill. The Office of Information and Technology is deferring IT solutions for the remaining Forever GI Bill sections until FY 2019, after the bulk of the Benefits Delivery Network is decommissioned to have a more modern technology stack on which to either make remaining changes or position the Department to be able to pursue alternative service offerings.

Questions for the Record from Rep. Bilirakis:

Question 60: The budget request includes $727 million for direct medical research, a 14 percent increase over fiscal year 2018 levels. One of my priorities on the Committee is to examine efforts to improve research and treatment for veterans who may be experiencing negative health effects due to toxic exposure such as burn pit inhalation during their military service. What is the VA doing to further this goal?

VA Response: The Office of Research and Development (ORD) is undertaking multiple approaches in the effort to progress knowledge forward of long-term health effects caused by airborne and open burn pit hazards. Based on the Institute of Medicine, Research Advisory Committee, and physician-driven recommendations, investigator-initiated as well as intra- (VA) and inter- (National Institute of Health and DoD) governmental partnerships are ongoing. These efforts include prospective

and longitudinal studies, molecular and biomarker discovery, genetic phenotyping, pre-clinical modeling, and clinical trials. In some studies, biorepositories have been developed to store biospecimens collected from Gulf War Veterans for ongoing and future research. Additional cost-estimate research has been initiated from the Health services research and development service. See below for highlights:

VA Investigator initiated projects:

VA ORD also solicits proposals from individual VA investigators for research projects related to the health of Veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn. The request for applications issued by ORD is entitled ″Merit Review Award for Deployment Health Research (OEF/OIF/OND),″ and it lists the health effects of burn pits as a specific area of emphasis for this research.

VA ORD is currently funding the following single-site research projects which deal with respiratory health issues in this population:

- Targeting HSC-derived Circulating Fibroblast Precursors in Pulmonary Fibrosis; Investigator: Amanda C. LaRue, PhD; Charleston, SC (10/1/2013-9/30/2018): Exposure sand and other airborne particulates cause pulmonary fibrosis (scarring) which reduces the ability of the lung to function properly, and this study is designed to determine the mechanism by which fibrosis-inducing cells develop (in mice) from hematopoietic stem cells (HSCs) and to determine if their presence can be used as an early biomarker for this condition.
- Mechanisms of Cigarette Smoke-Induced Acute Lung Injury; Investigator: Sharon Rounds, MD; Providence, RI (7/1/2015-6/30/2019): This study is designed to understand the mechanism by which acrolein, a component of cigarette smoke and burn pit smoke, damages lung cells and leads to respiratory difficulties and conditions like Acute Respiratory Distress Syndrome (ARDS) and COPD.
- Pulmonary Vascular Dysfunction after Deployment-Related Exposures; Investigator: Michael Falvo, PhD; East Orange, NJ (10/1/2017-9/30/2021): Small particulate material can deposit in the lungs and prevent the lungs from properly exchanging oxygen with the blood. In this study, gas exchange will be measured, and in cases where there is damage to the lungs, changes in blood chemistry will be monitored to develop laboratory tests that will be useful for diagnosing the condition.

Intra-VA and Inter-partnership projects:

Based on a 2011 Institute of Medicine report, a prospective study of the long-term health effects of deployment-related exposures in military personnel was recommended. VA investigators have designed a study that aims to assess the link between land-based deployment in Iraq, Afghanistan, Kuwait, or Qatar with the current pulmonary health of a representative sample of Army, Marine, and Air Force personnel.

- Pulmonary Health and Deployment to Southwest Asia and Afghanistan; Study Chairs: Eric Garshick, MD and Susan Proctor, DSc, Boston, MA; Paul Blanc, MD, San Francisco, CA (5/1/2016-9/30/2022): This two-phase, cross-sectional cooperative study consists of a survey and clinical examination of a representative sample of Veterans (Army, Marine, and Air Force personnel). Phase 1 collects self-reported health and military service information from a national sample through a mail survey or telephone interview. Phase 2 consists of in-person data collection procedures, including more extensive health, military service, and exposure questionnaires and pulmonary function testing. A pilot study is determining the optimal methods for recruiting participants, assessing participation rates and other factors that may influence participation, and demonstrating the feasibility of the techniques being used to reconstruct the levels of individuals' past exposures to particulate matter. These techniques, recently reported on in three journal articles by VA researchers and colleagues from Harvard and other institutions, involve the use of satellite data and airport visibility readings to help map pollution patterns and exposures that may have affected troops. Data from the National Aeronautics and Space Administration will be used to help with efforts to conduct this state-of-the-art approach to studying airborne exposures. Approximately 10,000 Veterans will be recruited at a total of six sites to participate in surveys and pulmonary function tests (PFTs). The results of current PFTs will be linked to each Veteran's exposure to particulate matter in the air during deployment.

Question 61: The budget request includes $8.6 billion for veterans' mental health services. Part of this funding accounts for the critical one-year period following uniformed service and transition to civilian life. The Committee has had multiple hear-

ings and roundtables on the transition assistance process. Please detail the measures VA expects to take over the next year to improve this transition process.

VA Response: VA plans to improve the transition process for Servicemembers during the critical 1-year period following uniformed service to civilian life through the following efforts:

- Developed a module within the revised Transition Assistance Program (TAP) VA Benefits I and II curriculum specifically addressing how transitioning Servicemembers can maintain their health following transition which includes a section on emotional wellness. Additionally, the section provides awareness of the growing number of people who are diagnosed with depression, and lists resources offered by VA for suicide prevention (e.g., crisis hotlines, websites, and support organizations).
- Implementing facilitated health care registration, which is an increased effort to register transitioning Servicemembers in VA health care by submitting their Application for Health Benefits (VA Form 10-10EZ) while they are in the VA Benefits I & II Briefings. This process will result in eligible Veterans having their applications adjudicated immediately after military separation or discharge.
- Leveraging VA Whole Health peer outreach and wellness groups to address transitioning Servicemembers' and Veterans' mental health needs, in addition to Transition Care Management and more traditional mental health services.
- Collaborating with interagency partners to collect feedback on post-separation outcomes via a post-separation assessment. Implementation of the assessment will give VA the opportunity to ensure TAP is employing the right tactics to help our Servicemembers transition successfully. It will also allow us to conduct data-driven evaluation of the effectiveness of TAP and the long-term impact of interagency transition services. Additionally, VA is working with interagency partners to review ″at risk″ populations for identification, tracking, and servicing to enhance effectiveness.
- VA and DoD are working collaboratively to extend the availability of Military One Source resources for a full year following discharge.

Question 62: The Bay Pines Health System recently experienced major facilities problems in a domiciliary housing homeless veterans; the building lacked heat and hot water for months. I escalated the issue to the Secretarial level and appreciate the swift action that was, at that point, taken. However, I am baffled as to why quicker action wasn't taken at the local level. Please further explain why this situation was allowed to develop and why the Health System or VISN did not address it earlier-was it a lack of dollars, or merely a lack of common sense in prioritizing dangers to the health and wellbeing of our most vulnerable veterans?

VA Response: VA has numerous contingency plans for mitigating any risk and ensuring the overall safety and well-being of Veterans; we also have access to numerous resources and expertise across the organization. The specific situation with Bay Pines VA Health System (BPVAHCS) was due to issues that occurred when powering up their outbuildings' post Hurricane Irma; which is a required and critical part of their emergency operations plan for sustainment. Appropriate oversight and guidance is sought through the appropriate channels, in this case additional technical guidance was sought through Contracting and Office Capital Asset Management Engineering and Support.

Mental Health leadership and care team members continually assessed Veteran concerns as they were raised. The total time from when the decision was made to replace the steam line end to end, to the time that a contract was awarded, was approximately 60 days. This is not an unrealistic timeframe as a full assessment of the project needed to happen to ensure it was appropriate in scope and complexity. This is a required element of the contracting process to ensure that all technical and safety specifications maintain compliance with industry and VHA standards.

Question 63: The budget proposal includes a narrative that the separate Community Care account, which has existed for the last several years, has restricted VA medical center directors from managing their budgets effectively. Please provide specific examples of this.

VA Response: The Budget proposes to merge the Medical Community Care appropriation with the Medical Services appropriation, as was the case prior to 2017. The current multiple medical care appropriations structure, including mandatory and discretionary resources, presents a significant administrative burden to the Medical Center Directors. While not insurmountable, it does not permit the Medical

Center leadership to easily leverage all the tools available for providing Veterans with the care they need. Having both Medical Services and MCC aligned under one appropriations account would allow Medical Center Directors the flexibility needed to expediently address care-related issues in ways that are beneficial to our Veterans.

1. Prior to the implementation of the MCC account, VA medical centers locally allocated funds between VAMC salaries and care in the community, ensuring Veterans had timely access to care. This flexibility was lost with the inception of the MCC account. This proposal allows the previous flexibility while ensuring timely access to care and to strategically and efficiently use the funds. Below are specific examples:

a. A VA Medical Center has a physician vacancy that has been unfilled for some time, but is able to finally hire someone for that position. Because the workload associated with this new hire would have been reflected in community care in the recent past, the VAMC would like to move the funds back in-house and provide the care at lower cost, rather than purchasing it from the community. Under the current appropriation structure, moving this position from community care back into VA requires a time consuming transfer process, and in the interim, and the VAMC must identify in-house funding offsets, that could limit clinical care in another area.

b. A rural VAMC provides 1,200 sleep studies each month through care in the community at a cost of $864,000 a year. Total estimated staffing and supply costs to bring those services in-house is estimated to be $450,000 a year, but the process of transferring funds between appropriations accounts is time consuming and administratively burdensome causing the medical center to purchase sleep studies in the community at almost twice the cost of providing the care in-house.

c. A VAMC has sufficient operating room capacity, outpatient clinical space, and equipment to provide clinical services, but lacks the flexibility to convert community care funds to medical services funds in a timely manner. As a result, the operating rooms may sit idle since the VAMC cannot access ″community care funds″ to pay for these procedures in-house.

2. The current multiple medical care appropriations structure also negatively impacts existing sharing agreements with adjacent university hospitals. VA sharing agreements are funded with the Medical Services appropriation. When medical centers exceed the annual allotted budget for the sharing agreement(s), the medical center is required to send Veterans for care in the community for the remainder of the fiscal year. For specialty care, such as orthopedic surgeries, the cost is frequently much more costly than through the sharing agreement. With a consolidated account, a VAMC could provide these services in-house, likely at a lower rate than what may be available in the community

3.Strategic investment in capital equipment and staffing is limited without the flexibility to transfer funds expeditiously between appropriations. With the combined appropriation medical center directors will have more flexibility to reallocate the MCC funds to purchase necessary equipment as well as to fund necessary salaries. As one specific example, a VAMC currently sends out all low-dose Computerized Tomography scans to the community at an average cost of $200 a scan. The VAMC would like to realign the community care funds to provide this service in-house at an average cost of $125 with equipment and staff capacity.

Question 64: What measures is VA taking to involve community health centers in the planning of community care consolidation, and what role is envisioned for them when consolidation is implemented?

VA Response: The VA Community Care Network (CCN) Contract Request for Proposal (RFP) provides language for the CCN contractors to make every reasonable attempt to ensure access to federally Qualified Healthcare Centers as part of CCN. The CCN RFP does not specifically address community health centers (CHC). The CCN RFP does require the CCN contractor to customize the network for each VA Facility therefore the VA Facility leadership can request the CCN Contractor to engage local CHCs.

Question for the Record from Rep. Bost:

Question 65: The budget includes a request for $172 million for the Office of Inspector General to strengthen accountability. Will this level of funding be sufficient to properly enforce accountability throughout the VA?

VA Response: OIG will respond directly to Rep. Bost and will provide OCLA with a copy (Gromek).

Question 66: Do you need any new authority to establish clearer cut qualifications for positions within VA, such as Human Resources?

VA Response: The Human Resources Management - GS-0200 series is under Title 5 and as such, is covered by the Office of Personnel Management's (OPM) General Schedule Qualification standards. These standards are written broadly for Government-wide application and are not intended to provide detailed information about specific qualification requirements for individual positions at a particular agency. It is important to note that all Federal agencies use the OPM approved qualification standards, and creating VA specific standards, would negatively impact VA's ability to recruit human resources (HR) professionals from other Federal agencies and retain current HR staff. OPM states that such information (i.e., a description of the specialized experience requirements for a particular position) should be included in the vacancy announcements issued by the agency. As such, rather than standardized qualification requirements across VA, individual vacancy announcements are customized to reflect the specialized experience (qualification requirements) for the particular position itself. VA already utilizes this method of applying specialized qualification requirements in all HR job announcements. Additionally, performance standards are developed on an annual basis for each HR position in the Department. These performance standards are aligned with the specific functions and specialized area of HR being performed by each HR professional.

Question for the Record from Rep. Poliquin:

Question 67: The budget request includes $25 million to reimburse the Judgment Fund. Will this zero out VA's liabilities to the Judgment Fund?

VA Response: No. The outstanding Judgment Fund reimbursement to Treasury is $229.9 million for nine projects. The FY 2018 appropriation of $10 million for the Judgment Fund will leave a balance of $219.9 million. The FY 2019 requested appropriation of $25 million will leave a balance of $194.9 million and serves as a down payment to address the overall requirement.

Questions for the Record from Rep. Dunn:

Question 68: VA's suggested Major Construction appropriation language includes the following. Please explain the intended meaning and effect of, ″regardless of the estimated costs of the project.″ B

.of which $400,000,000 shall be available for seismic improvement projects and seismic program management activities regardless of the estimated costs of the project.

a. Please explain how VA has changed the prioritization of seismic projects in the existing SCIP process.

VA Response: The use of the word ″regardless″ is a technical change to clarify that major funds could be used for seismic needs/projects that were partially funded by the Minor, Medical Facilities and National Cemetery accounts:

″.and of which $480,000,000 shall remain available until expended, of which $400,000,000 shall be available for seismic improvement projects and seismic program management activities regardless of the estimated costs of the project.″

Seismic is still a high priority and included in the SCIP process - as it has been in previous years. For 2019, seismic projects shown in the SCIP 2019 prioritized list were not included in the minor or NRM funding request and would be funded out the newly created seismic fund.

b. Please explain why, after this change, creation of a separate seismic fund and project ranking list is necessary.

VA Response: A separate seismic initiative fund is necessary to more effectively and efficiently meet significant critical seismic corrections for VA buildings at various locations across the Nation. VA has identified a seismic risk in excess of $7 billion at its facilities. The proposed seismic fund would correct singular buildings, as opposed to campus wide corrections. Projects would be limited to providing similar functions and maintain original purpose. Further, the reduction of some legislative requirements will allow for quicker correction of documented deficiencies. This initiative will allow VA to move forward quickly and without delay to address the critical seismic issues that are currently putting Veterans, staff, and other VA visitors at-risk.

ROE TO OIG

The Honorable Phil Roe, M.D. Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington , DC 20515

Dear Mr. Chairman:

Enclosed is a response from the Office of Inspector General (OIG) to a question for the record received from Congressman Mike Bost following the February 15th hearing before the Committee on the U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2019. We request that it be added to the hearing record.

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J.MISSAL

Enclosure

Copy to: The Honorable Tim Walz, Ranking Member
The Honorable Mike Bost

Office of Inspector General, Department of Veterans Affairs

Response to Questions for the Record from

House Committee on Veterans ' Affairs Hearing on

U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2019

65. The budget includes a request for $172 million for the Office of Inspector General to strengthen accountability . Will this level of funding be sufficient to properly enforce accountability throughout the VA?

VA Office of Inspector General Response: The budget request for the Office of Inspector General (OIG) for fiscal year (FY) 2019 of $172 million will not be sufficient for the OIG to fully meet its mission of effective oversight of the programs and operations of VA While that amount would represent an increase over the OIG's funding of $164 million for FY 2018, it falls short of even the OIG's actual FY 2018 operating budget of $175.5 million (which includes $15.9 million of carryover due to a late hiring cycle that was out of synch with the budget cycle).

There will not be a carryover of that size for FY 2019 as those funds will have been expended primarily on new hires to conduct our oversight work. In addition, we are now funding our Office of Contract Review approximately $5 million that was previously paid by VA through a reimbursable agreement, and there are other increased costs in FY 2019. Consequently, an FY 2019 appropriation of $172 million would require adecrease of about 28 OIG staff. This would result in a likely curtailment of some of our oversight priorities if OIG staffing and resources decrease at a time when VA is experiencing growth, including large and complex projects such as VA's new electronic health records initiative , improving VA's financial systems, enhancing and consolidating VA's IT systems, and expansion of community care programs. The OIG will need additional funds to not only conduct oversight of these costly programs, but also to expand our investigations of other high-risk VA programs, such as construction, procurement, education benefits, and the delivery of timely and quality healthcare. The VA OIG's staffing is among the smallest ratio of oversight staff to agency staff across the Inspector General community. Moreover, the OIG budget represents less than .1 percent of VA's overall budget, which again is less than a significant number of OIGs at other cabinet level agencies. An FY2019 appropriation of $172 million will undermine progress achieved to ″right size″ the OIG oversight capacity to the growth and demands of VA's new initiatives.

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