S. HRG. 114–233

THE FISCAL YEAR 2016 BUDGET FOR VETERANS PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

FEBRUARY 26, 2015

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FEBRUARY 26, 2015

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APPENDIX

THE FISCAL YEAR 2016 BUDGET FOR VETERANS PROGRAMS

THURSDAY, FEBRUARY 26, 2015

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:33 a.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Cassidy, Rounds, Tillis, Sullivan, Blumenthal, Murray, Sanders, Brown, Tester, Hirono, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I will call to order this meeting of the Veterans' Affairs Committee of the U.S. Senate and welcome everybody on a snowy, cold Washington day.

We are glad to have you, Mr. Secretary, Dr. Clancy, and all the members of your staff here, and glad to have the veterans service organizations in to talk about VA's budget request and the current pending budget for the U.S. Department of Veterans Affairs.

I am going to open—we changed the rules a little bit. We are going to have an opening statement by the Chairman and an opening statement by the Ranking Member. Then we are going to let any other Member who wants to make a public statement make a closing statement so we can go straight to your testimony and give you all the time that you need to do so. We will receive questions based on the early-bird rule and we will alternate between Republican and Democrat in that order so we will be fair and equitable and everybody here gets a chance to ask questions.

I am going to be liberal with the time, because I think this is a very important hearing and it is very important for us to understand the Department's request. It is equally important for the Department to understand what we really want to see out of the Veterans Administration, so thank you for being here.

Secretary MCDONALD. Thank you, Mr. Chairman.

Chairman ISAKSON. I thought last night, when I prepared for what I might say this morning, about the last 2 years on the Committee, because it has been a rough 2 years in a lot of ways for the VA; a rough 2 years for us. There have been a lot of increases in money to VA. There have been increases in parameters. The Veterans Choice bill has passed and we are trying now to implement that. We have had the challenges with mental health, particularly

with veterans' suicide rates. We have had a lot of other problems with construction and other departments within the Department.

So, you could look back and say, this thing is a mess. The fact of the matter is that you have—with your estimate for employees in fiscal year 2017, you are going to have 305,000 employees in the Veterans Administration health care, just the health care system alone. That is a big organization, exceeded only by the United States military in its totality as the largest employer in government. So, you have a big organization that could be—and sometimes is—unwieldy.

We, as a committee, want to try to make it work as seamlessly as possible. We want the funding to be appropriate, but not in the excess; and, we want our attitude and the attitude of the Department to be equally focused on the veteran and the veterans' health care, not on ourselves.

To that end, I did a little math last night—I am a Georgia graduate, so I might be corrected by some of these people that went to higher institutions than that—but I was trying to figure out the ratio of employees to the number of beneficiaries in the VA. There are 6.5 million veterans—I believe that is the right number—who are using VA health care. Is that correct?

Secretary MCDONALD. That is very close. Yes, sir.

Chairman ISAKSON. OK. And, there are going to be 305,000 employees in veterans' health systems if you get the number of employees you want in 2 years?

Secretary MCDONALD. That is correct. Yes, sir.

Chairman ISAKSON. That is a ratio of 21 veterans to every one employee in the VA. That is pretty good—that is a lot better than the pupil-teacher ratio you have in public education today. So, I am not sure that we have a shortage of employees nearly as much as we have not every oar in the water rowing in the same direction in terms of those that are following you and your leadership, or in terms of us and the support we are giving to you.

I am troubled by the lack of detail in some of your request, and I want to get into that in the Q and A portion, because I know there is a request for 5,000 more employees in the VA over the next couple of years. I understand why it is being asked for, but I ask the question, if the ratio is 21-to-1 now, are we going to lower it to 19-to-1; and is that going to improve anything, because more is not necessarily better in any business. In fact, sometimes more can be more cumbersome than it can be healthy.

Second, as I told The American Legion yesterday—we have had a hearing with the Legion, we had the Disabled American Veterans hearing—and in both hearings, the VSOs made it clear that while they understood Veterans Choice, they wanted to make sure we understood that they did not want Veterans Choice to replace VA health care.

So, I want to repeat what I told the Commander from Kansas and Nebraska yesterday at the end of the meeting. We need the VSOs and the Veterans Administration putting their heart and soul behind making Veterans Choice work, not as a replacement for VA health care, but as a force multiplier for VA health care, and to be the VA health care of the 21st century. Veterans Choice was not designed to be a replacement. It was designed to be a help us

deal with the problem that existed in the administration in the delivery of health care, in appointments, in timeliness, and in proximity to specialized care that veterans oftentimes need.

So, one of the things you are going to hear me say over and over and over again, which I hope the Veterans Administration employees and the VSO leaders are listening to this, they need to get onboard and start going forward. There is an old saying that a radio disc jockey in Atlanta had. "Them that's going, get in the wagon. Them that ain't, get out of the way." That is what we need to do on Veterans Choice. We need to make it work to address the problems that the VA health care has experienced and get health care to our veterans in the most timely and seamless way we can. I am dedicated and committed in my service as Chairman to doing just that.

As I close my remarks—I have got coins for the Members, by the way, which they will be getting when we come back next week, that have the IDWIC acronym on it, "I Do What I Can" to help with veterans health care. We want you to do what you can to make it work for us. We welcome you today. We look forward to your testimony.

I am pleased to now turn to the Ranking Member, Senator Blumenthal.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, for that very eloquent opening statement.

I am very eager to turn to our witnesses and to our colleagues for questions, but let me just state right at the outset, Secretary McDonald, I have welcomed many of the steps that you have taken as a beginning toward MyVA, meaning all of our VA, and you were hired to do a very dramatic turnaround. And, as with many tremendous challenges, that turnaround will take time and very likely stronger action than you have been willing to devote so far.

The Congress responded to the debacle of delays and inadequate health care in some facilities by approving a measure that also is still a work in progress. The Choice Act has been shockingly underutilized, as you and I have discussed. The reasons are uncertain and unknown at this point.

What is really necessary now is better data and stronger information. That has been one of the downfalls of VA to this point: the lack of reliable, accurate, truthful information. It was the downfall of your predecessor. Very simply, certain people in the VA lied to us.

So, the oversight function of this body is tremendously important to our work like demanding reliable, accurate data and information for your decisions. As you know from being a very successful chief executive in the private sector, decisions are only as good as the information that underlies it, which is why I have posed some questions to you in the last couple of weeks. You have been very forthright and forthcoming in seeking to respond to them. I recognize that some of them will require time to answer.

I am hoping that we can answer them in order to better know, for example, about some of the factors that are contributing to the

underutilization of the Choice program, the illogical 40-mile interpretation—the American Legion Commander characterized it yesterday as "crazy," the confusing clarification around the geographic barriers and the definition of the term "facilities" in a meaningful way. Beyond the health care issue, there are all kinds of questions as to the backlog of disability claims, GI Bill benefits for education, physical facilities, and infrastructure. These challenges are more important than ever.

I look forward to your testimony today on what the VA is doing and also how it can better connect with the Department of Defense. One of the still important problems is the disconnect in so many respects, whether it is information technology, or drug formularies. I spent some time yesterday talking to General Chiarelli about the formulary issue, which he has very pointedly and importantly raised.

There are a variety of challenges ahead that this budget seeks to address, and I welcome the partnership between your team and the Congress in seeking to address them and, finally, doing more about not only health care in general, but mental health in particular. The Clay Hunt SAV Act was a proud achievement of this Committee on a very bipartisan basis, and I want to thank again the Chairman for putting it so high on the list of priorities for this Committee to address.

Thank you very much, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Blumenthal.

We are going to recognize the Secretary. I told the Secretary before the hearing that I am not going to run the clock on him. I will gavel him down if he starts repeating himself, but this is very important testimony and a very important budget request. I want to give you the time to make your request and make your points. You are recognized for your presentation.

STATEMENT OF HON. ROBERT A. MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CAROLYN M. CLANCY, M.D., INTERIM UNDER SECRETARY FOR HEALTH; HON. ALLISON A. HICKEY, UNDER SECRETARY FOR BENEFITS; RONALD E. WALTERS, INTERIM UNDER SECRETARY FOR MEMORIAL AFFAIRS; HON. HELEN TIERNEY, ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER; AND STEPHEN W. WARREN, EXECUTIVE IN CHARGE AND CHIEF INFORMATION OFFICER, OFFICE OF INFORMATION AND TECHNOLOGY

Secretary MCDONALD. Thank you, Chairman Isakson and thank you, Ranking Member Blumenthal, Members of the Committee. Thanks for the opportunity to discuss VA's 2016 budget and 2017 advance appropriations requests. I appreciated the opportunity to speak with many of you during the past few weeks to gather your questions and to be able to try to address them. We appreciate the partnership.

We also appreciate the President's and Congress' steadfast support for veterans, their families, and survivors, as well as the assistance of Veterans Service Organizations.

As VA emerges from one of the most serious crises the Department has ever experienced, we have before us a critical opportunity

to improve care for veterans and build a more efficient and more effective system. With your support, VA intends to take full advantage of this opportunity.

Members of this Committee and VSOs share my goal to make VA a model agency with respect to customer experience, an example for other Government agencies. With efficient and effective operations, we look to be comparable to the top private sector businesses in order to best meet the Nation's obligations to all veterans.

The cost of fulfilling our obligations to veterans grows over time because veterans' demands for services and benefits continue to increase even after wars end.

This chart (see Veterans Receiving Service-Connected Disability Compensation on pg. 8 of 23) shows that 22 percent of Vietnam veterans were receiving service-connected disability claims in 2014, four decades after the war ended. We expect the percentage will continue to increase.

It is worth remembering that today, almost 150 years after the Civil War, VA is still providing benefits to the child of a Civil War veteran.

We still have troops in both Iraq and Afghanistan, yet in the last decade, we have already seen a dramatic increase in the demand for benefits and care. This chart (see Percent of Veterans Receiving Disability Compensation on pg. 10 of 23) shows that from 1980 to 2000, the percentage of veterans receiving VA compensation was stable at about 8.5 percent. But in just the last 14 years, since 2001, the percentage has dramatically increased to 19 percent.

Simultaneously, the number of claims and medical issues in claims has soared. Look at this chart. As this chart shows (see Claims and Medical Issues Completed on pg. 15 of 23), in 2009 VBA completed almost 980,000 claims. In fiscal year 2017, we project we will complete over 1.4 million claims. That is a 47-percent increase.

But there has been a more dramatic growth in the number of medical issues in claims, 2.7 million in 2009 and a projected 5.9 million in 2017. That is a 115-percent increase in just 8 years.

Now, these increases were also accompanied by a rise in the average degree of veterans' disability compensation. For 45 years, from 1950 to 1995, the average degree of disability was 30 percent. Since 2000, the average degree of disability has risen to 47.7 percent, nearly 50 percent, as this chart (see Average Degree of Disability on pg. 10 of 23) shows.

While it is true that the total number of veterans is declining—and the total number of veterans is declining—the number of those seeking care and benefits is increasing.

Fueled by more than a decade of war, Agent Orange-related claims, an unlimited claims appeal process, increased medical claims issues, far greater survival rates of those wounded, more sophisticated methods for identifying and treating veterans' medical issues and demographic shifts, and as we said, the population is aging, veterans' demand for services and benefits exceeded VA's capacity to meet them. It is important that Congress and the American people understand why that is happening.

The most important consideration is that America's veterans are aging, and their health care requirements and demand for benefits increase as they age and as they retire.

Look at this chart (see Number of Living Veterans on pg. 9 of 23). This chart reveals an astounding shift. Just 40 years ago, only 2.2 million veterans were 65 years old or older. That is 7.5 percent of the population, and you can see that in 1975 based on the size of the red bar.

But look at 2017. We expect 9.8 million veterans will be 65 years or older. That is 46 percent of veterans. Just look at the size of the red bar from 1975, the year I graduated from West Point, to what we project in 2017. So, we now serve an older population with more chronic conditions who are less able to afford private care.

Currently, 11 million of the 22 million veterans in this country are registered, enrolled, or use at least one VA benefit or service. More are demanding VA services and care than ever before.

The requirement for women veterans and mental health care has increased dramatically. Over 635,000 women veterans are now enrolled for health care, and over 400,000 actively use VA. That is double the number using the VA in the year 2000. Annual increases in women veterans seeking care are about 9 percent, and this trend will continue. Our Women Veterans Call Center now connects with about 100,000 women veterans per year.

In 2014, over 1.4 million veterans with a mental health diagnosis enrolled in VHA, and we had 19.6 million mental health outpatient encounters. Those are increases of 64 percent and 72 percent, respectively, since the year 2005.

Since its inception in 2007, the Veterans Crisis Line has answered over 1.6 million calls and assisted in over 45,000 rescues. As veterans witness the results of the positive changes VA is making and as the military downsizes, the number of veterans choosing VA services will continue to rise. It should, and they have earned it.

We are listening hard to what veterans, Congress, employees, and VSOs are telling us. What we hear drives us to a historic department-wide transformation, changing VA's culture and making veterans the center of everything we do. We call it MyVA, and it entails many organizational reforms to better unify the Department's efforts on the behalf of veterans.

These are the strategies at MyVA. We have them listed in our written testimony as our five major themes.

First, We are working to improve the veteran experience so that every veteran has a seamless, integrated, and responsive customer service experience every single time. We are working with the very best companies in customer experience in the private sector to do that.

Second, we are improving employee experience by eliminating barriers to customer service and focusing on our people and culture so we can better serve veterans. We have no hope of taking care of veterans unless we take care of our employees.

Third, improving our internal support services, which is where we think we can improve our productivity dramatically and, therefore, get more resources to serve veterans.

Fourth, establish a culture of continuous improvement to identify and correct problems faster and, importantly, replicate solutions at all facilities.

And, number 5, enhance strategic partnerships. Strategic partnerships, like the Choice Act, as the Chairman said, are a force multiplier, and we want to take advantage of that.

MyVA revolutionizes culture and reorients VA around the needs of veterans, measuring success by veterans' outcomes as opposed to internal metrics. Reorganizing the Department geographically is a first but substantial step in achieving this goal.

In the past, VA had nine disjointed geographic organization structures, one for each of our nine lines of business. Our new unified organization framework has one national structure, as shown on this chart (see pg. 5 of 23). The new structure has just five regions, aligning VA's disparate organization boundaries into a single framework. You will notice this framework and these boundaries are by State lines, which they were not previously. This facilitates internal coordination and collaboration among business lines; it creates opportunities for local level integration, pushing responsibility lower in the organization. It promotes effective customer service. Veterans will see one VA rather than individual, disconnected organizations.

Last, MyVA is about ensuring sound stewardship of taxpayer dollars. We will integrate management improvement systems such as Lean Six Sigma across operations to ensure we balance veteran-centric service with operational efficiency. But we need the help of Congress. VA cannot be a sound steward of the taxpayers' resources with the asset portfolio we currently carry. No business would carry a portfolio like the one we have. Veterans deserve better. It is time to close VA's old, substandard, and underutilized infrastructure. We have 900 VA facilities that are over 90 years old and more than 1,300 that are over 70 years old. VA currently has 336 buildings that are vacant or less than 50 percent occupied. That is 10.5 million square feet of excess, costing an estimated $24 million annually to maintain. These funds could be used to hire roughly 200 registered nurses for a year or to pay for 144 primary care visits for veterans or to support 41,900 days of nursing home care for veterans in community living centers. We need your support to do the right thing.

MyVA reforms will take time, but over the long term, they will enable us to better provide veterans the services and benefits they have earned and that our Nation has promised them. Our 2016 VA budget will allow us to continue transforming the intent of MyVA. It requests $168.8 billion—$73.5 billion in discretionary funds and $95.3 billion in mandatory funds for benefit programs. The discretionary request is an increase of $5.2 billion, which is 7.5 percent above the 2015 enacted levels. This will provide resources to continue serving the growing number of veterans seeking care and benefits. The budget will increase access to medical care and benefits for veterans. It will address infrastructure challenges, including major and minor construction, modernization, and renovation. It will end the backlog of claims and will end veterans' homelessness by the end of 2015. It will fund medical research and pros-

thetics research; and it will address IT infrastructure and modernization needs.

The resources required in the 2016 budget request are in addition to those Congress provided last year in the Veterans Choice Act. The VA has fully implemented this act and will be expanding our outreach and providing more information to veterans with a nationwide public service announcement, which I would be happy to show you sometime today during the hearing if the Committee's time permits.

We do not know at this time how many veterans will use the provisions of the act to seek non-VA care or how much that care will cost. As this chart demonstrates (see pg. 11 of 23), there is a high degree of uncertainty about resources required. Our current estimates range from a demand low of about $4 billion to a high of about $13 billion over the 3-year program.

We will need flexibility within our budget to ensure that we have the right resources at the right places at the right time to provide veterans the timely care they need, regardless of wherever they choose to receive it.

As an example of this flexibility, we are currently exploring options to review the 40-mile provision, as we have talked, of the Choice Act to get more veterans the care that they want and need. I look forward to and I want to continue to work with the Committee Members on the redefinition of this 40-mile limit and work with other Members of Congress and veteran stakeholders on this critical issue as we gain more information about how veterans are using the Choice Act.

We meet today at a historically important time for VA and the Nation. Next Wednesday, March 4, will mark the 150th anniversary of President Lincoln's solemn promise to care for those who have borne the battle and for their families and their survivors. That is VA's primary mission. It is the noblest mission of supporting the greatest clients of any agency in the country.

Mr. Chairman, Members of the Committee, thanks again for your support for veterans, for working with us on these budget requests, for your patience in listening to my presentation, and for making things better for all veterans. We look forward to your questions.

[The prepared statement of Secretary McDonald follows:]

PREPARED STATEMENT OF HON. ROBERT A. MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF THE HONORABLE ROBERT A. MCDONALD
SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

BUDGET REQUEST FOR FISCAL YEAR 2016

FEBRUARY 26, 2015

Chairman Isakson, Ranking Member Blumenthal, Distinguished Members of the Senate Committee on Veterans' Affairs:

Thank you for the opportunity to present the President's 2016 Budget and 2017 Advance Appropriations (AA) requests for the Department of Veterans Affairs (VA). This budget continues the President's staunch, unwavering support for Veterans, their families, and survivors. We value the support to VA that Congress has demonstrated in providing the resources and legislative authorities needed to honor our Nation's Veterans.

This is a critical moment for VA. We are emerging from one of the most serious crises the Department has ever experienced. But with this crisis, VA also has before it perhaps the greatest opportunity in its history to enhance care for Veterans and build a more efficient and effective system. We are listening hard to what Veterans, Congress, employees, Veterans Service Organizations (VSOs), and other stakeholders are telling us. Since my nomination on June 30, 2014, I have made 96 visits to VA field sites -- including 26 visits to VA Medical Centers, seven visits each to VA Community-Based Outpatient Clinics and Homeless Veteran program sites. I participated in the Los Angeles Point-in-Time Homeless Veterans count. I've made six visits to VA Regional Offices and five visits to VA cemeteries. I have witnessed first-hand the operations at VA polytrauma centers, a Veterans community living center, a hospice, an insurance center, and a domiciliary. I have attended nineteen Veteran engagements through partnerships and sixteen stakeholder events. I have visited twelve medical schools and universities to recruit newly minted clinical professionals for VA's healthcare system. All of these visits are influencing the way VA is moving forward. We are implementing an historic department-wide transformation, changing VA's culture, and making the Veteran the center of everything we do. We aspire to make the VA a model agency that is held up as an example for other government agencies to follow with respect to customer experience and stewardship of the taxpayer's resources. We strive to be comparable to the very best private sector businesses, with efficient and effective operations.

The President's 2016 Budget will allow VA to operate the largest integrated healthcare system in the country, including over 1,900 VA points of healthcare and approximately 9.4 million Veterans enrolled to receive care; the tenth largest life insurance provider, covering both active duty Servicemembers and enrolled Veterans; a compensation and pension benefits program serving over 5.2 million Veterans and survivors; an education assistance program serving 1.2 million students; a home mortgage program with a portfolio of over 2 million active loans guaranteed by VA; and the largest national cemetery system that leads the Nation as a high-performing organization, with projections to inter 129,200 Veterans and family members in 2016. VA's 2016 budget request is essential to begin to address the resource requirements necessary to move VA into the future, address the crisis we are in, and meet our obligation to provide timely, quality health care and services to Veterans.

The 2016 Budget for VA requests $168.8 billion -- $73.5 billion in discretionary funds, including medical care collections, and $95.3 billion in mandatory funds for Veterans benefits programs. The discretionary request reflects an increase of $5.2 billion (7.5 percent) above the 2015 enacted level. The budget also requests a 2017 AA for Medical Care of $63.3 billion and a first-time AA request of $104.0 billion for three mandatory accounts that support veterans' benefit payments (i.e., Compensation and Pensions, Readjustment Benefits, and Insurance and Indemnities). These investments, together with the 2016 Budget, will provide authorities, funding, and other tools to enhance service to Veterans in the short term while strengthening the underlying VA system to better serve Veterans in the future. However, more resources in certain areas will be required to ensure that the VA system can provide timely, high-quality health care into the future. In the coming months, the Administration will submit legislation to allow the VA Secretary to reallocate a portion of Veterans Choice Program funding to best meet Veteran needs. This will allow the Secretary to make essential investments in VA system priorities in a fiscally responsible, budget-neutral manner.

MyVA -- Driving Reforms and Improving Efficiency

In order to transform VA into an organization of which Veterans, employees, and Americans can be proud, we are beginning with a commitment to critically assess ourselves. Transformation must start with organizational reforms to better unify the Department's efforts on behalf of Veterans. These reforms will take time, but will center around the ICARE values and provide Veterans the services and benefits they have earned and deserve.

The goal of MyVA is to reorient the Department around the needs of Veterans. MyVA will create a VA that eliminates barriers to putting customers first; measures success by the outcomes to Veterans as opposed to our internal processes; and integrates across programs and organizations to optimize productivity and efficiency. MyVA focuses on five major themes:

- Improving the Veteran experience
- Improving the employee experience, and achieving "people excellence" so we can better serve Veterans
- Establishing a culture of continuous improvement
- Improving our internal support services
- Enhancing strategic partnerships

The overarching principle is our focus on the Veteran experience. We want every Veteran to have a seamless, integrated, and responsive customer service experience every time. We are taking the first step towards better integration of the Department by moving from nine separate regional maps to one. This realignment will align VA's disparate organizational boundaries into a single framework, easing internal coordination and collaboration between business lines, and allowing VA to provide customer service training and capabilities across the agency. This will make the department more seamless to Veterans, who will begin to perceive their interactions with one VA, rather than individual organizations. The new organizational framework will have five geographically-named regions, which we worked with Veteran Service Organizations to name: North Atlantic, Southeast, Midwest, Continental, and Pacific.

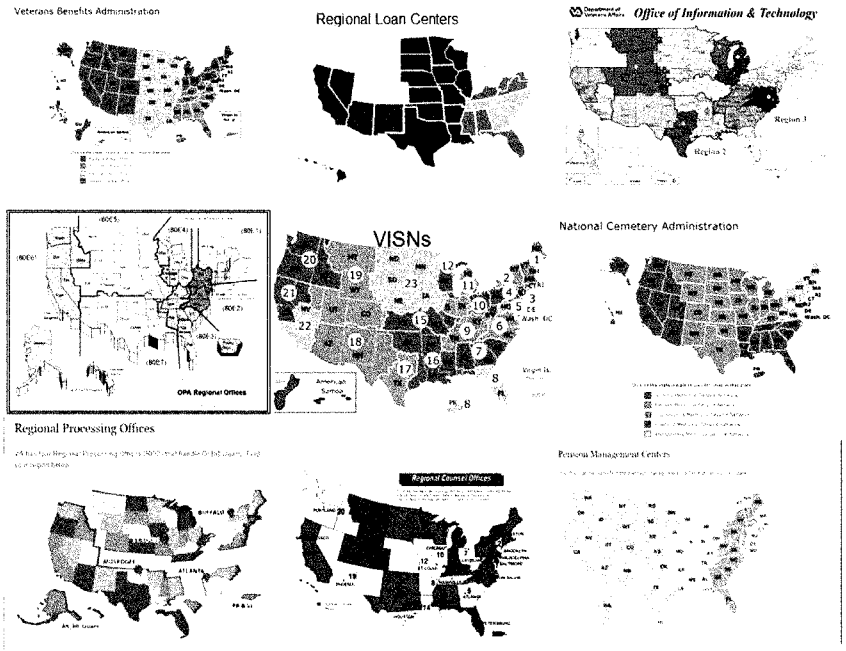
MyVA will empower employees with the tools they need to better serve Veterans, and will revolutionize VA's culture by emphasizing continuous improvement, setting conditions at the local level for issues to be raised, addressed, and solutions replicated across as many facilities as needed to achieve enterprise level results.

MyVA is also about ensuring that VA is a sound steward of the taxpayer dollar. By improving our internal support services, we will ensure that our processes support VA employees serving Veterans and that we effectively balance exceptional Veteran-centric service with operational efficiency. We are using a business lens to assess all aspects of VA operations and will pursue changes to allow VA to deliver care and services more efficiently and effectively while delivering the highest value to Veterans and taxpayers. By exploring opportunities to enhance Strategic Partnerships, we will ensure the best and most effective organizations—public, private, non-profits, and volunteer—work with VA to best serve Veterans.

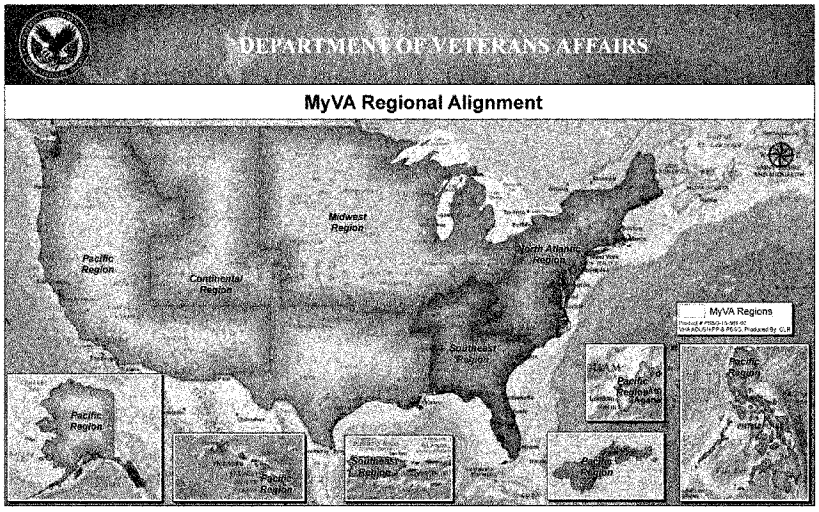
In addition, we are creating a new Digital Services Team, comprised of the country's best developers, designers, and digital product managers, who will work across VA to design and deploy world-class digital services for America's Veterans. Our digital services experts will help the Department achieve the MyVA vision through improved electronic access to VA services that works across Veterans' computers, tablets, kiosks, and mobile devices.

We anticipate this will be the largest department-wide transformation in VA's history. It will be the product of ideas and insights shared by Veterans, employees, members of Congress, VSOs, and other stakeholders.

Before: VA's Nine Organizational Maps

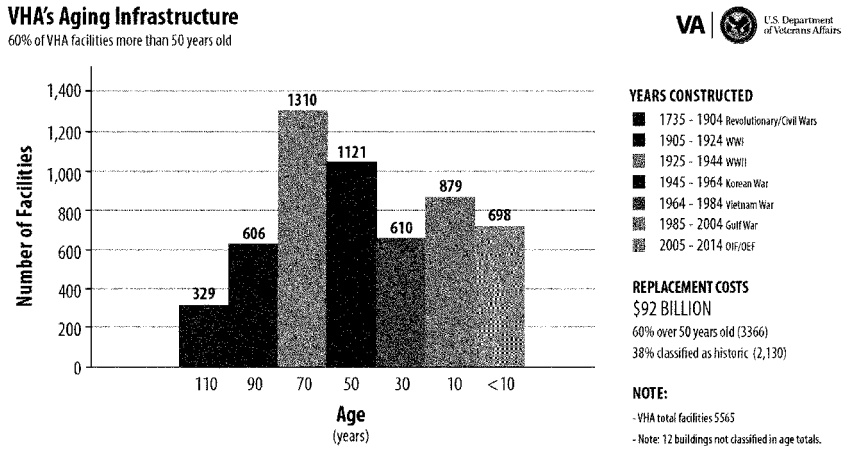


After: A Single, Coordinated Framework



Closing Unsustainable Facilities

VA cannot be a sound steward of the taxpayer's resources with the asset portfolio it is carrying. No business would carry such a portfolio – and our Veterans deserve better. It is time to close VA's old, substandard, and underutilized facilities. Of 5,565 VA medical facilities – which include hospitals, clinics, warehouses, and other assets that support medical operations – more than 900 facilities are over 90 years old, and more than 1,300 facilities are over 70 years old. Overall, 60 percent of VA facilities are more than 50 years old.



We need to move forward with closing locations that are not economically sustainable and old, outdated buildings that are challenging to maintain and provide little or no value to our customers. VA currently has 336 buildings that are vacant or less than 50 percent occupied, which are excess to our needs. This means we have to maintain over 10.5 million square feet of unneeded space – taking funding from needed Veteran services. For example, we estimate that it costs VA $24 million annually to maintain and operate vacant and underutilized buildings. These funds could be better used to hire roughly 200 Registered Nurses for one year; pay for 144,000 Veteran primary care visits; provide Veterans 13,500 bed days of inpatient care; or support 41,900 days of nursing home care for Veterans in Community Living Centers. The President's 2016 Budget includes two legislative proposals that would aid VA in disposing of these unnecessary assets. The first is the government-wide Civilian Property Realignment Act, which would enable Federal agencies to pursue consolidation and disposals in a streamlined way. The second proposal would authorize VA to pursue Enhanced-Use Lease (EUL) agreements for purposes beyond the currently authorized purpose of creating supportive housing. Our existing EUL authority does not allow VA to enter into a wide range of innovative agreements that could benefit Veterans.

VA faces many obstacles to rightsizing our capital asset portfolio. For example, under an Enhanced Use Lease project, VA and a third-party developer tried to demolish the vacant building shown below in order to provide land for the development of housing for homeless Veterans, but the state historic preservation office prevented VA from

taking action. I have met with National Historic Building advocates to discuss repurposing the buildings we close, and look forward to a spirited, positive dialogue on this issue.

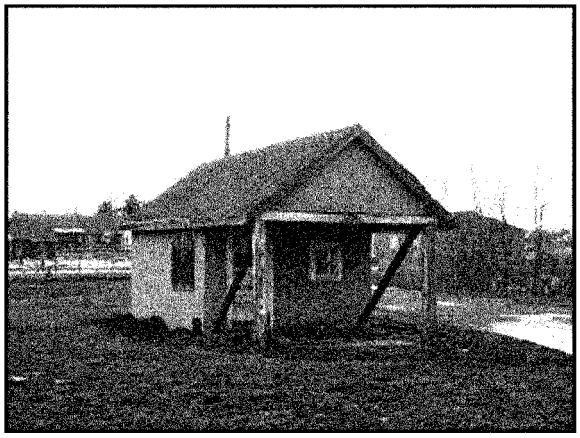


Photo: Minneapolis, Minnesota vacant building, quartermaster gas station, built in 1932.

As the Veteran population has migrated, VA's capital infrastructure has not kept pace. We continue to operate medical facilities in legacy locations, in places where the Veteran population is small or shrinking. We do this at the expense of creating new access and right-sized capacity for larger numbers of Veterans in the locations where the Veteran population is growing. For example, in one hospital with an operating capacity of ten medical beds, the average daily patient census is 5 patients or less. At this facility, VA is required to maintain adequate infrastructure such as lab, x-ray, and other support in place continuously, regardless of the facility's low utilization rate. The cost per patient to maintain a small operation such as this one is higher than the cost in some of our large, highly complex facilities. Additionally, the patient volume and complexity of care make it difficult, if not impossible, for physicians and nurses to maintain clinical skills and competencies. This example is not an anomaly – there are many others in VA.

VA needs to better align its health care facilities to meet today's health care delivery models, which are shifting away from long inpatient stays to greater outpatient care. We also need to modernize our facilities to ensure they provide ready access to women, who now comprise 11 percent of all Veterans and 20 percent of our military. Where hospitals no longer make sense, due to a declining Veteran population or

demographic shifts, VA must look for ways to partner with local hospitals and health care systems to serve Veterans. Much of health care today is about creating partnerships and interdependencies to better serve patients and to contain costs. VA must be part of that.

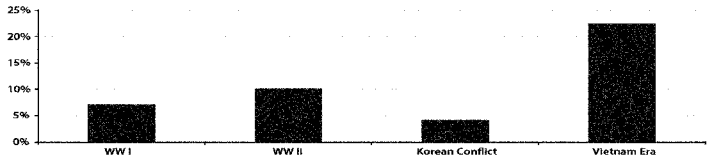
We know that it is difficult for Members of Congress to contemplate the closing of a facility in their own District, even when that facility is underutilized and wasteful. Yet, given the current and future demands on the VA system, we cannot afford to waste scarce resources on an inefficient system. We would like to work with Members of Congress to do the harder right, rather than the easier wrong. We ask for your help to realign our Medical facilities to best serve our Veterans and shed facilities that are not economically viable and no longer provide value.

Veterans' Demand for Services and Benefits

We know that Veterans' demand for services and benefits continues to rise for decades after conflicts end. And we know that the Veteran population is aging. In 2017, 9.8 million, or 46 percent of the 21.1 million Veteran population will be age 65 or older. This compares with 2.2 million, or 7.5 percent, in 1975. Veterans' care often occurs many years after they served in uniform, so this is a long-term issue for VA. Just since 2002, the number of Veterans receiving outpatient services has grown by more than 76 percent.

Veterans Receiving Service Connected Disability Compensation
40 years after conflict ends

VA | U.S. Department of Veterans Affairs

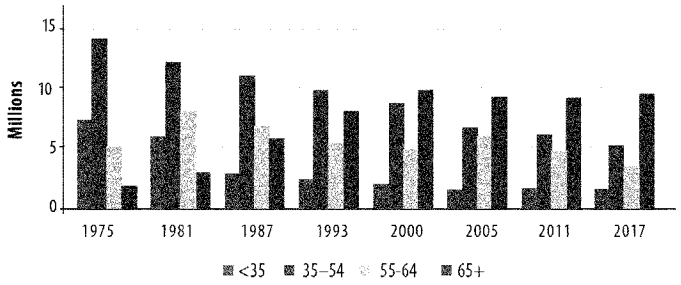


	World War I Veterans (1958)	World War II Veterans (1985)	Korean Conflict Veterans (1993)	Vietnam Era Veterans (2014)
SCD Compensation	203,654	1,048,976	198,492	1,624,656
Total Population	2,876,000	10,399,000	4,692,000	7,247,000
Percentage	7.08%	10.09%	4.23%	22.42%

Note: Date in parentheses is the date of data used in the chart
Data Source: 1958 VA Annual Report; 1985: VA Trend Data 1961-1985; 1993 VA Trend Data 1969-1993; 2014: VBA OPIA and Veteran Population Model

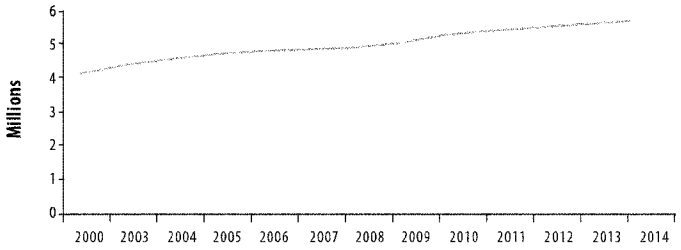
Number of Living Veterans
by Age Groups, 1975-2017

VA | U.S. Department of Veterans Affairs



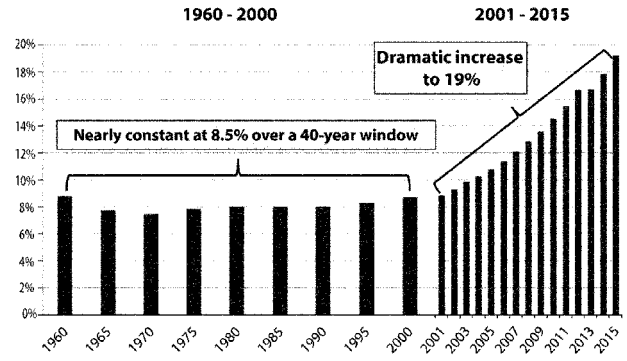
Number of Veterans Unique Outpatients
2002-2014 (in millions)

VA | U.S. Department of Veterans Affairs

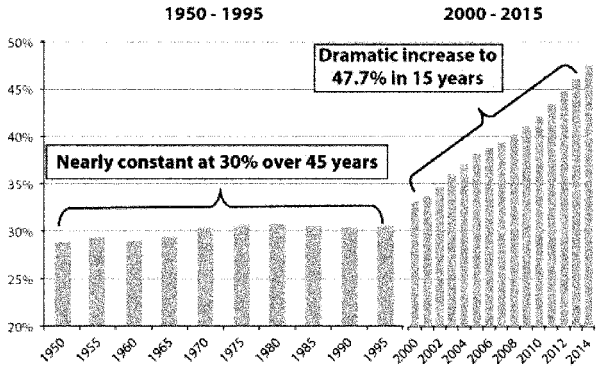


Fueled by more than a decade of war, Agent Orange-related disability compensation claims, an complex, non-linear claims appeal process, demographic shifts, increased medical claims issues, and other factors, Veterans' demand for services and benefits has exceeded VA's capacity to meet it. VA has worked with the Ad Council on a pro bono advertising campaign to encourage more Veterans to sign up for their benefits, but we are reluctant to launch the campaign at a time when our capacity is stretched to its limit.

Percent of Veterans Receiving Disability Compensation



Average Degree of Disability



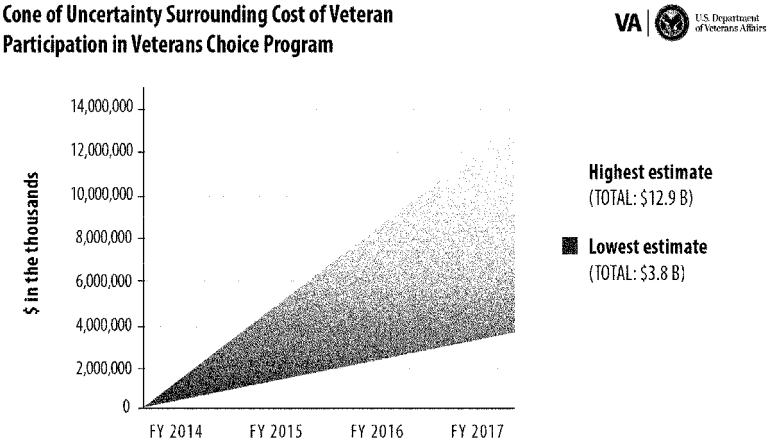
We must ensure that demand for services and benefits does not outstrip our capacity to provide them. VA must build the capacity now to meet future demand. We

look forward to working with you to identify and prioritize spending to best serve the interests of Veterans and our Nation.

The Veterans Access, Choice, and Accountability Act of 2014

The funding provided in the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act) was an important step in moving VA on the path to improved access to care for Veterans. VA greatly appreciates these additional resources provided by the Congress - $15 billion to allow Veterans additional access to health care within the community and address current access and capacity shortfalls that are inherent within VA. While it is clear that purchased care plays an important role, it should not be seen as a replacement for a strong and vital Veterans' healthcare system.

The emergency resources provided in the Veterans Choice Act are not permanent, but are being used to address the current access crisis, but do not fully address VA's longstanding capital infrastructure requirements Because VA has limited experience with the new Veterans Choice Program, it is difficult to predict Veterans' use of the program, or its interaction with the medical care base budget. Our estimates of the total health care costs for the Choice Program range from a low of $3.8 billion to a high of $12.9 billion over the three-year program.



Data source: VA Office of the General Counsel, Economic Impact Analysis for RIN 2900-AP24, "Expanded Access to Non-VA Care through the Veterans Choice Program"

The variance is the result of significant uncertainty surrounding eligible Veterans' participation and utilization of non-VA medical services. Two categories of Veterans are eligible to participate -- those living outside the Act's 40-mile distance from a VA facility, and those who are on a waiting list for more than 30 days. Each eligible Veteran must make his or her own decision about care in the community. For example, a Veteran may prefer to be seen at the VA by his or her regular doctor, even though there is a waiting period, rather than see a new private sector physician in a shorter time period. Also, wait times may be high in the community for specialty appointments, and Veterans may elect to receive their specialty care from VA.

Ensuring Veterans Access to Care

Veterans are demanding more services from VA than ever before. The number of Veterans who are seeking VA medical care continues to grow steadily. Compared to FY 2009, the number of patients is projected to increase by 20 percent by FY 2016. We now serve a population that is older, with more chronic conditions, and less able to afford care in the private sector. And, as Veterans see the results of the positive changes we are making, we are confident that the number of Veterans utilizing VA services will rise. Currently, 11 million of the 22 million Veterans in this country are registered, enrolled, or use at least one VA benefit or service. Our 2016 budget requests the necessary resources to allow us to serve the growing number of Veterans who selflessly served our Nation.

In 2016, the number of Veterans enrolled in VA medical care will be nearly 9.4 million, an increase of 1.6 percent from 2015. Also, VA expects to provide more than 101 million outpatient visits in 2016, an increase of 2.8 million visits from 2015. Workload will continue to rise as the military downsizes and Veterans regain trust in the VA. In addition, survival rates among Americans who served in conflicts have increased, and more sophisticated methods for identifying and treating Veteran medical issues continue to become available.

The 2016 Budget requests $60.0 billion for medical care, an increase of $4.2 billion (7.4 percent) over the 2015 enacted level. The increase in 2016 is driven by Veterans' demand for VA health care as a result of demographic factors, and economic assumptions, investments in access; and high priority investments for Caregivers, new Hepatitis C treatments, and support for Veterans Health Information Systems and Technology Architecture (VistA) Evolution. The 2016 request supports programs to end Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. The 2016 appropriations request includes an additional $1.3 billion above the enacted 2016 AA for Veterans medical care. This is

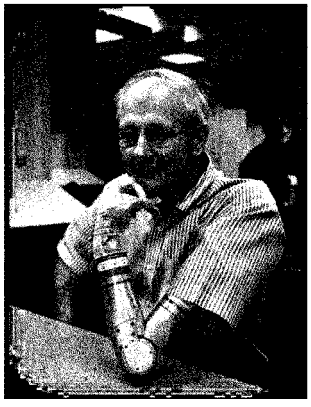
the first year VA will be seeking additional funding in all three medical care accounts that are funded by advance appropriations. The request includes approximately $3.3 billion annually in medical collections in 2016 and 2017.

For the 2017 Advance Appropriations for medical care, the current request is $63.3 billion. This request reflects great uncertainty surrounding the impact of the Veterans Choice Act on VA operations in 2017. This estimate will be revised as VA gains greater experience with implementation of the Veterans Choice Act.

Ending Veteran Homelessness

As President Obama has said, too many of those who once wore our nation's uniform now sleep in our nation's streets. The Administration has made the elimination of Veteran homelessness a national priority. In 2009, we set an ambitious plan to end veteran homelessness by the end of 2015. We have made substantial progress toward this goal — as of January 2014, overall Veteran homelessness is down 33 percent since 2010, and we have achieved a 42 percent decrease in unsheltered veteran homelessness. Through unprecedented partnerships with federal and local partners, we have greatly increased access to permanent housing, a full range of health care including primary care, specialty care, and mental health care; employment; and benefits for homeless and at risk for homeless Veterans and their families. As a result of these investments, in fiscal year 2014, more than 260,000 homeless or at-risk Veterans (including formerly homeless Veterans) received VA specialized services.

In 2016, VA will continue to focus on prevention and treatment services. The Budget requests $1.4 billion for VA homeless-related programs, including case management support for the HUD-VASH voucher program, the Grant and Per Diem Program, the Supportive Services for Veteran Families program, and VA justice programs. The 2016 Budget supports VA's plan to end Veteran homelessness by emphasizing rescue for those who are homeless today, and prevention for those at risk of homelessness.



Medical and Prosthetic Research

VA has a legacy of innovation and cutting-edge research that is as broad and historically significant as it is profound—and often unrecognized. Few are aware that VA research developed the cardiac pacemaker, the first successful liver transplant, the nicotine patch, and the world's most advanced prosthetics—including VA's revolutionary "Braingate" breakthrough that makes it possible for totally

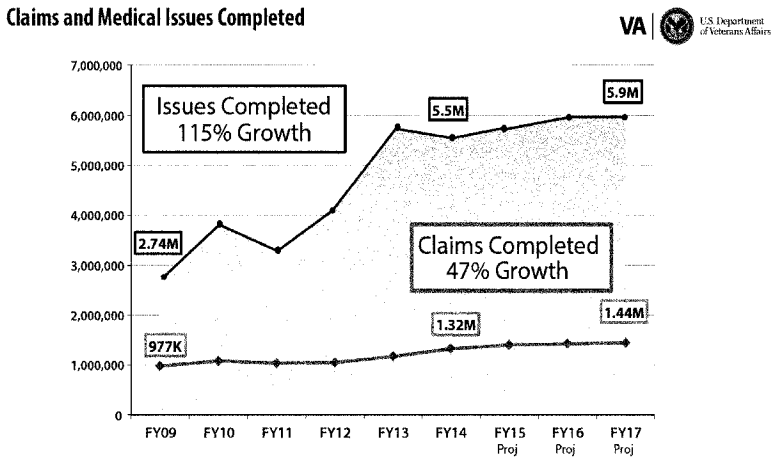
paralyzed patients to control robotic arms using only their thoughts.

VA research also has led to major breakthroughs and advances in medical science and care—Posttraumatic Stress Disorder, or PTSD, and Traumatic Brain Injury, or TBI, being only two of many. In 2016, Medical Research will be supported through a $621.8 million direct appropriation, and an additional $1.2 billion from VA's medical care program and grants. Total funding for Medical and Prosthetic Research will be over $1.8 billion in 2016.

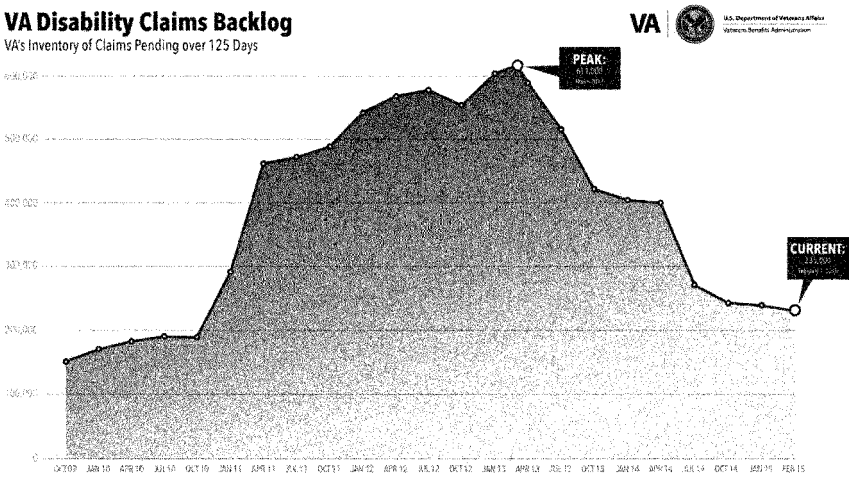
The 2016 Budget includes a $10.2 million strategic initiative to support improvements in VA medical care through research focused on a "Learning Health Care System." A learning health care system is one that is responsive to new information, adapts to implement more effective clinical practices, and is committed to an ongoing mission of excellence, supported by a culture of self-reflection and continuing education. Through five interlocking research streams – measurement science, operations research, point-of-care research, provider behavior, and randomized program implementation – this initiative proposes to broaden existing research by systematically capturing, assessing, and translating the lessons from each care experience into improved methods of delivering care to Veterans.

Continuing the Transformation of the Veterans Benefits Administration

Improving quality and reducing the length of time it takes to process disability compensation claims is integral to our mission of providing the care and benefits that Veterans have earned and deserve in a timely, accurate, and compassionate manner. The disability rating claims workload continues to increase, due to the reduction in military forces, Servicemembers returning from wars, and the aging of the Veteran population. Also, the complexity of the workload continues to grow because Veterans are claiming greater numbers of disabling conditions and the nature of disabilities -- such as PTSD, combat injuries, diabetes and related conditions, and environmental diseases -- is becoming increasingly complex.



Despite these challenges, VBA has decreased the disability claims backlog by more than 60 percent as of January 31, 2015, since its peak in March 2013 (from 611,000 to 235,000), and we are on track to meet the President's goal to eliminate the disability claims backlog by processing all claims in 125 days by the end of 2015. VBA's success in reducing the backlog has occurred, in part, because of its strong reliance on mandatory overtime by claims processors. However, this strategy is unsustainable. It strains employee-management relations and is inconsistent with our goal to improve the employee experience so they can be empowered to better serve Veterans. We must right size VBA's workforce and more effectively manage the use of management practices such as the use of mandatory overtime and continue progress toward eliminating the disability claims backlog.



We are taking the lessons learned in eliminating the disability claims backlog and applying them to transform business processes supporting the fiduciary program, the delivery of non-rating benefits, and the appellate workload.

For 2016, VA requests $2.7 billion for VBA for general operating expenses, an increase of $165.8 million (6.6 percent) over the 2015 enacted level. These resources will support 21,871 Full-Time Equivalent (FTE) employees and allow VA to administer disability compensation and pension benefits totaling $83.1 billion to over 5.2 million Veterans and survivors; education benefits and vocational rehabilitation and employment benefits and services to nearly 1.3 million participants; VA guaranty of more than 431,000 new home loans; and life insurance coverage to 1.1 million Veterans, 2.3 million Servicemembers, and 3.1 million family members.

As VBA continues to receive and complete more disability rating claims, the volume of appeals, non-rating claims, and fiduciary field examinations increases correspondingly.

- Appeals. Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA continues to receive and complete record-breaking numbers of disability rating claims in recent years (1.3 million claims completed in 2014), the volume of appeals increases concomitantly. VBA currently has approximately 290,000 pending appeals.

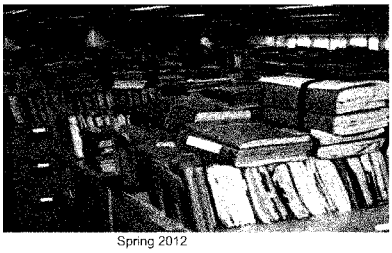
- Non-rating claims. VBA's success in completing rating decisions has driven an increase in non-rating claims. In 2015, VBA expects to receive 2.9 million non-rating claims and review actions, an increase of 7.4 percent over 2014 (2.7 million) and 12.5 percent over 2013 (2.4 million).

- Fiduciary program. In 2014, VA's fiduciary program protected more than 173,000 beneficiaries, which is a 42 percent increase in the number of beneficiaries from 2011 (122,000). Primary drivers of the growth in this program are the increase in the total number of beneficiaries receiving VA benefits and an aging beneficiary population. In 2014, fiduciary personnel conducted over 86,000 field examinations, and VBA anticipates field examination requirements to exceed 117,000 in 2016.

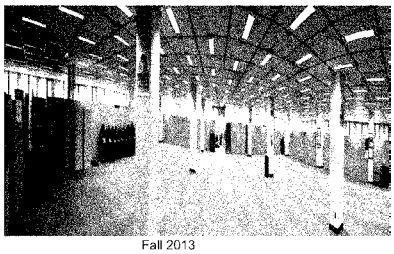
To ensure all aspects of the claims process are improved for Veterans, VBA is requesting additional claims processors and field examiners. VBA is requesting $85 million to fund 200 appeals processors, 320 non-rating claims processors, 85 fiduciary field examiners, and 165 support personnel (including 13 FTE for the National Work Queue (NWQ)), for a total of 770 additional FTE. VBA employees – over 50 percent of whom are Veterans - are leading advocates for Veterans, Servicemembers, their families, and Survivors and are key to our success. With the additional 770 employees, VA will provide Veterans with more timely decisions on their appeals and non-rating claims, and conduct thousands more vital fiduciary home visits.

VBA is able to accommodate additional staff within existing space requirements by efforts underway to digitalize Veterans claims folders, building on success to date. One example is the VBA office in Winston-Salem, North Carolina, which is shown below before and after VBA digitized Veterans' paper records.

Winston-Salem Regional Office: Before and After Transformation



Spring 2012



Fall 2013

The VBA request includes $140.8 million for continued investment in the Veterans Claims Intake Program (VCIP), which converts paper claims into an electronic format and enables the electronic transfer of medical and personnel records. This

electronic transfer is critical to creating the necessary digital environment that supports end-to-end electronic claims processing for each stage of the claims lifecycle. As of December 2014, over 28,000 users of the Veterans Benefits Management System (VBMS) could access over one billion electronic images converted from paper.

The Budget request for the 2017 Advance Appropriations for the Compensation and Pensions appropriation is $87.1 billion; the Readjustment Benefits advance appropriation request is $16.7 billion; and the Veterans Insurance and Indemnities advance appropriation is $91.9 million. These amounts reflect the current estimates for the resources that would be necessary to continue these benefit programs in 2017, and will be revised as necessary in the mid-session review of the 2016 Budget, as VA monitors workload and monthly expenditures.

Enhanced Focus on Information Technology Solutions

Funding for IT infrastructure and services is at the heart of VA's mission, because IT affects every aspect of VA's ability to serve Veterans by providing easily accessible, quality health care and benefits. To offer a view of the scope of VA's IT dependency, VA IT systems support operations at every VA location, with over a million devices on the network. VA's current challenges present a unique opportunity to employ innovative Information Technology (IT) solutions to accelerate changes that will better serve Veterans. Veterans and their families of all ages are increasingly more comfortable using leading-edge technology to communicate and access health care and benefits. Our IT challenge is to safely and securely deliver Veterans that leading-edge experience—fluid mobile solutions, creative apps, and user-friendly websites that rival the best in technology outside VA.

The $4.1 billion request represents an increase of $230 million (6 percent) above the 2015 enacted level. The request consists of $505 million for development of new IT products; $2.5 billion for sustainment, $892 million for more than 7,615 staff and administrative support, and $223 million for related support services. The request will sustain our infrastructure while making necessary investments in IT support for critical business processes, such as streamlining benefits processing, enhancing and modernizing VA's electronic health record, enhancing data security, and achieving health data interoperability with the Department of Defense.

The 2016 request funds key development projects for Veterans' access ($192 million), disability claims backlog elimination ($105 million), and VistA Evolution ($82 million). The request of $2.5 billion for IT sustainment will fund the replacement of the oldest hardware that has fallen beyond its useful lifespan; the development of registries to track homeless Veterans; communications systems, wireless, and mobile solutions; software license procurement; and information security.

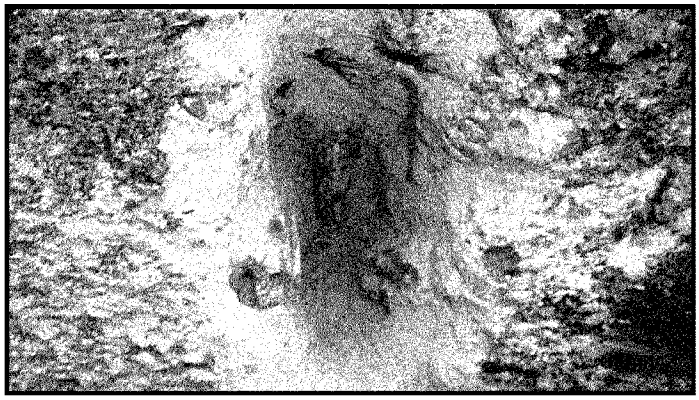
Investing in VA's Infrastructure

The 2016 Budget requests $1.6 billion for VA's major and minor construction programs, an increase of $493 million (47 percent) above the 2015 enacted level. Providing access to care and ensuring that Veterans are safe when they are in a VA facility, drive our capital requirements. The capital asset budget demonstrates VA's commitment to address critical major construction projects that directly affect patient safety and seismic issues, and reflects VA's promise to provide safe, secure, sustainable, and accessible facilities for Veterans. The request enables VA to invest in our facilities to fulfill VA's mission to deliver timely and high quality care and services to our Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gaps identified in our Strategic Capital Investment Planning (SCIP) process.

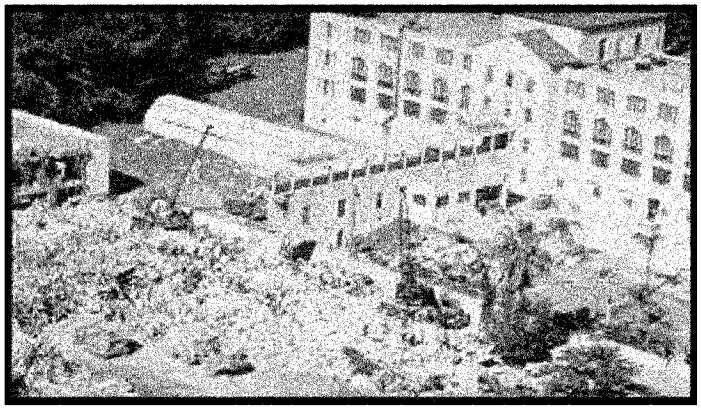
Major Construction

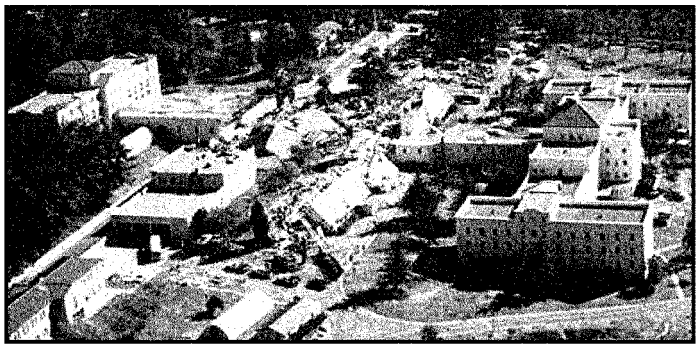
VA acknowledges the challenges we have experienced in building the Denver Replacement Medical Center facility in Aurora, Colorado. We are committed to doing what is right for the Veterans in Denver and completing this major construction project without further delay. VA is dedicated to getting the project back on track in the most effective and cost efficient manner possible.

The 2016 Budget requests $1.144 billion for major construction, an increase of $582 million from the 2015 enacted level. The request provides funding for nine on-going VHA major medical facility projects. Correction of seismic deficiencies is a primary focus of our 2016 Major construction request. The request includes funds to address seismic problems in facilities in America Lake, WA; and in San Francisco, West Los Angeles, and Long Beach, CA. These projects will correct critical safety and seismic deficiencies that pose a risk to Veterans, VA staff, and the public. The photograph below shows a known seismic deficiency at the San Francisco Medical Center -- built in 1933 -- wherein the rebar does not extend into the "pile cap."



We must prevent the devastation and potential loss of life that occurs because our facilities are vulnerable to earthquakes – such as occurred in 1971 in San Fernando, California. As shown below, a 6.5-magnitude earthquake caused two buildings in the San Fernando Medical Center to collapse and 46 patients and staff to lose their lives.





The Major construction request also includes funds for medical facility improvements and cemetery expansion project in St. Louis, MO (Jefferson Barracks); new medical facility project in Louisville, KY; construction of a new outpatient clinic and a columbarium in Alameda, CA; realignment and closure of the Livermore Campus in Livermore, CA; and construction of a replacement Community Living Center in Perry Point, MD. New, replacement, and renovated medical space will provide additional capacity to treat Veterans through more efficient configurations, with the implementation of Patient-Aligned Care Teams, and the establishment of multi-exam rooms per provider – similar to the private sector. Once the projects are completed, Veterans will be served in modern and safe facilities.

The major request also includes funding for four cemetery gravesite expansion projects at: Puerto Rico National Cemetery; Willamette National Cemetery in Portland, OR; Riverside National Cemetery in Riverside, CA; and Barrancas National Cemetery in Pensacola, FL. These projects offer VA the ability to provide access to burial services through new and expanded cemeteries and prevent the closure to new interments in existing cemeteries.

Minor Construction

In 2016, the minor construction request is $406.2 million. The requested amount would provide funding for ongoing and newly identified projects that renovate, expand and improve VA facilities, while increasing access for our Veterans. VA continues to focus on a balance between continuing to fund minor construction projects that can be implemented quickly to maintain and repair our aging infrastructure, while using major construction funding to address life-threatening safety and seismic issues that currently exist at multiple VA medical facilities.

Leasing

The 2016 Budget includes a request to authorize 18 major medical leases to provide access to Veterans and enhance our research capabilities nationwide. The proposed major medical lease projects are to replace, expand, or create new outpatient clinics and research facilities. The request includes resubmission of five leases that were originally submitted in 2015, but have not yet been authorized.

Since the inception of the EUL program, VA has entered into approximately 100 EUL projects, leveraging approximately 5.8 million square feet and over 1,000 acres of excess property to repurpose in support of Veterans, VA, and local communities across the country. VA needs the support of Congress for our proposed amendments to expand our current EUL authority beyond supportive housing projects so we can better leverage our excess space for Veterans. In addition, this proposed enhancement would allow VA to monetize unneeded assets to raise capital to address needed investments in VA's system.

Legislation

In addition to presenting VA's resource requirements, the 2016 President's Budget proposes legislative action that will benefit Veterans. VA's most critical legislative request is for a significant update to VA's authorities for purchase of non-VA healthcare. The Administration is proposing a streamlined process for purchasing health care needed for Veterans in those circumstances where it cannot be purchased through existing contracts or sharing agreements. The proposal takes care to preserve important features and protections found in traditional contract vehicles. Current law is simply not adequate to support the continued level of access to health care we need to secure for our Veterans. We look forward to detailed engagement with the Committee and your staff.

Other important proposals include adjustment for VHA personnel authorities, one of which will greatly help in having employee scheduling flexibility that will both make hospital operations more efficient, and help attract the most qualified medical professionals to work for VA, especially for critical round-the-clock operations. VA in this budget also again proposes changes in disability claims processes, an area where reform is greatly needed, for the benefit of all Veterans who are frustrated with the time it takes to resolve claims and appeals. We are open to all ideas from the Committee and from VSO's to modernize this process, and make it work for Veterans. Our increased manpower and great strides in automation are helping, but these cannot replace statutory changes to modernize the process.

As mentioned earlier, VA will propose a measure that would allow a portion of the Veterans Choice Act funds to be used for essential operational requirements. In addition, the legislative proposals would allow for better coordination of care when a Veteran also receives other care at a non-VA hospital, by streamlining the exchange of patient information. Additionally, we propose allowing the CHAMPVA to cover children

up to age 26, to make that program consistent with benefits conferred under the Affordable Care Act.

To continue our priority to end Veteran homelessness, VA proposes increased flexibility in the Grant and Per Diem program to focus on the transition to permanent housing. Also among our proposals is a measure that would allow VA to speed payment of Dependency and Indemnity Compensation and other benefits to surviving spouses by eliminating the need for a formal claim when there already is sufficient evidence for VA to act. We are proposing legislation to eliminate the requirement for quarterly conference reporting. This requirement has impacted essential VA training and has taken a massive staff effort to produce the mandated reports. Since the beginning of fiscal year 2013, VA has spent $2.4 million to prepare these reports. These resources are better spent providing health care and benefits to Veterans. We greatly appreciate consideration of these and other legislative proposals included in the 2016 Budget and look forward to working with the Congress to enact them.

Closing

Veterans are VA's sole reason for existence and our number one priority. In today's challenging fiscal and economic environment, we must be diligent stewards of every dollar and apply them wisely to ensure that Veterans—our clients—receive timely access to the highest quality benefits and services we can provide and which they earned through their sacrifice and service to our Nation.

We also acknowledge the responsibility, accountability, and importance of showing measurable returns on that investment. You have my pledge that VA will do everything possible to ensure that the funds Congress appropriates to VA will be used to improve both the quality of life for Veterans and the efficiency of our operations. We are proud to be part of this VA team and feel privileged to be here serving Veterans at this key time in history. The work we do continues and grows for decades after the end of America's conflicts. Thank you for the opportunity to appear before you today and for your steadfast support of Veterans.

RESPONSE TO PREHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. The Secretary has undertaken an ambitious goal to reorganize the Department of Veterans Affairs (VA) into a more veteran centric organization. This initiative, called MyVA, intends to put the veteran first and give them the opportunity to choose how and where they are served. In addition, it is intended to integrate VA to increase productivity and efficiency across the Department.

a. In total, how much funding is requested for the MyVA initiative for fiscal year (FY) 2016 and for FY 2017?

b. If VA's budget is adopted, how many additional employees in total would be hired in relation to the MyVA initiative?

c. Please provide the breakdown of where those employees would be located, including how many would be located at VA's Central Office and how many would be located in the field.

d. Please provide a breakdown of what categories of positions those employees would fill.

VA Response (a-d). The 2016 Budget requests: (1) $3.5 million and 15 Full-Time Equivalent (FTE) employees for MyVA in the General Administration account, and (2) $76.3 million and 204 FTE supported from within the existing VA budget as reimbursable funded activities. As the process continues and the specific policy and program changes are identified, the Department will submit budget requests for implementation, beginning in FY17.

Question 2. Within the Medical Support and Compliance account, VA is requesting 5,006 new Full-time equivalent (FTE) employees and an increase of $283.7 million to support the Secretary's MyVA initiative. These new FTE would be in the field at the VA medical centers (VAMCs) and Veterans Integrated Service Networks (VISNs).

a. Please describe the analysis performed to determine whether 5,006 new FTE were needed as opposed to whether the duties of these new FTE could be performed as ancillary duties of existing employees.

Response. The Medical Support and Compliance FTE growth is not associated with the Secretary's MyVA initiative.

The additional positions are being added to the Medical Centers and VISNs to support and fulfill the Secretary's vision of becoming a more Veteran-centric organization and to be able to provide top-level customer service in a more efficient manner to our Veterans. These personnel will support healthcare workers in order to deliver the healthcare services that our Veterans expect.

Although the FY 2016 Revised Request estimate of 54,020 FTE is 5,006 more than the original FY 2016 Advance Appropriation estimate, it is only 1,206 more than the FY 2015 Current Estimate. The FY 2015 Estimate is largely based on FTE Operating Plans submitted by the Veterans Integrated Service Networks, and reflects a concerted effort to provide more support staff to VA clinical staff to enhance Veterans access to health care. The FY 2016 Revised Request increase of 1,206 FTE above the FY 2015 Current Estimate is a 2.3% increase, which is in line with VA's estimated increase in health care demand.

Medical Support and Compliance FTE

	FY 2013 Actual	FY 2014 Budget Estimate	FY 2014 Current Estimate	FY 2015 Budget Estimate	FY 2016 Adv. Approp.
FY 2015 Budget	48,610	49,929	50,303	49,014	49,014

	FY 2014 Actual	FY 2014 Actual	FY 2015 Current Estimate	FY 2016 Revised Request	FY 2017 Adv. Approp.
FY 2016 Budget	50,323	50,323	52,814	54,020	55,300
Change from Estimate	394	20	3,800	5,006	
Change from Previous Year	1,713	1,713	2,491	1,206	1,280

b. Please provide the full list of 5,006 positions, job descriptions, and the General Schedule or Title 38 pay grade(s).

Response. See table below. It should be noted that these staffing levels do not reflect the additional medical and clinical support staff added under the Veterans Choice Act to increase Veterans' access to medical care, which is accounted for separately in the budget.

Description	2016 Advance Approp.	2016 Revised Request	2016 Increase/ Decrease
Physicians	611	651	40
Dentists	15	10	(5)

Description	2016		
	Advance Approp.	Revised Request	Increase/ Decrease
Registered Nurses	2,960	3,365	405
LP Nurse/LV Nurse/Nurse Assistant	90	105	15
Non-Physician Providers	235	227	(8)
Health Technicians/Allied Health	1,206	1,119	(87)
Wage Board/Purchase & Hire	903	993	90
All Other [1]	42,994	47,550	4,556
Total	49,014	54,020	5,006

[1] All Other Category includes: Medical Records Clerk/Technician, Budget/Fiscal, Contract Administrator, Supply Technician, Medical Support Assistant, Administrative Support Clerk, Administrative Specialist, Police, Personnel Management Specialist, Management and Program Analyst, and other staff that are necessary for the effective operations of VHA Medical Support and Compliance

c. Would the new FTE report to the VAMC and/or VISN directors? If not, please provide the reporting structure for these positions.

Response. The majority of these new FTE will be supporting health care workers at VA medical centers and would report through their supervisory chain to the local Medical Center Director. Other FTE would be added for VA Consolidated Activities, such as Consolidated Mail Outpatient Pharmacies and Consolidated Patient Account Centers.

Question 3. The President's budget request indicates that "[i]n the coming months, the Administration will submit legislation to reallocate a portion of Veterans Choice Program funding to support essential investments in VA system priorities in a fiscally-responsible, budget-neutral manner." How much of the Veterans Choice Program funds, and to which programs, does the Administration propose to reallocate?

Response. It is too early in the implementation of the Veterans Choice Program to provide a detailed answer. VA is assessing Veterans' utilization of the Choice Program while also examining where the Veterans Choice funding could be utilized to meet the demand for Veterans services in VA's base program. VA's highest priority is ensuring that Veterans have timely access to high quality care. VA will work with Congress on any legislative proposal to ensure that budgetary resources are allocated in a way that maximizes Veteran access to care and services.

Question 4. The budget request includes an increase of $1.3 billion to the FY 2016 advanced appropriations for medical care. The majority of the increased funding would be for initiatives that are not included in the Enrollee Health Care Projection Model.

a. Please explain in detail what changed with these initiatives since the FY 2016 advanced appropriations request was sent to Congress in March 2014?

Response. See the attachment. The primary drivers of the increase were increased demand for health care services (which included the cost of new lifesaving Hepatitis C treatments), increased demand for Caregivers stipends, an increased estimate for the cost of activation of new health care facilities, increased investment in programs to assist homeless Veterans (largely increased HUD-VASH vouchers) and increased investment in non-recurring maintenance.

Update to the 2016 Advance Appropriations Request ($000)

Update to the 2016 Advance Appropriations Request
Excludes Veterans Choice Act
(dollars in Thousands)

Description	2016 Advance Approp.	2016 Current Estimate	Increase/ Decrease
Health Care Services	$49,882,074	$50,481,994	$599,920
Veterans Choice Program Cost-Shift		($452,000)	($452,000)
Long-Term Services and Supports:			
Institutional	$5,572,601	$5,526,958	($45,643)
Non-Institutional	$1,836,847	$1,933,555	$96,708
Long-Term Services and Supports [Total]	$7,409,448	$7,460,513	$51,065
Other Health Care Programs:			
CHAMPVA, Spina Bifida, FMP & CWVV	$1,854,870	$1,883,882	$29,012
Caregivers (Title 1)	$305,716	$555,096	$249,380
Indian Health Services (P.L. 111-148)	$38,649	$28,062	($10,587)
Camp Lejeune - Veterans and Family (P.L. 112-154)	$71,906	$19,720	($52,186)
Readjustment Counseling	$237,544	$243,483	$5,939
Other Health Care Programs [Subtotal]	$2,508,685	$2,730,243	$221,558
Ending Veterans Homelessness	$1,265,000	$1,393,000	$128,000
Healthcare Infrastructure Enhancements:			
VISTA Evolution	$208,265	$159,596	($48,669)
Non-Recurring Maintenance	$460,600	$708,000	$247,400
Activations	$130,000	$598,174	$468,174
Healthcare Infrastructure Enhancements [Subtotal]	$798,865	$1,465,770	$666,905
VA Legislative Proposals	$49,914	$49,375	($539)
Obligations [Total]	$61,913,986	$63,128,895	$1,214,909
Funding Availability:			
Appropriation	$58,662,202	$58,662,202	$0
Trns to North Chicago Demo. Fund	($252,073)	($259,145)	($7,072)
Trns to DoD-VA Health Care Sharing Incentive Fund	($15,000)	($15,000)	$0
Medical Care Collections Fund	$3,252,857	$3,226,548	($26,309)
Reimbursements	$266,000	$215,000	($51,000)
Funding Availability [Total]	$61,913,986	$61,829,605	($84,381)
Annual Appropriation Adjustment		$1,299,290	$1,299,290

Explanation of $1.299 Billion Increase

- **Ongoing health care services** estimate increased by $599.9 million, driven largely by estimates of the cost of new Hepatitis C treatments and updated actuarial trends based on the latest actual data.

- A reduction in projected base appropriations health care costs due to enactment of the **Veterans Choice Act**; VA estimates that $452 million in **requirements will shift from the regular program** as Veterans who would otherwise receive care in the VA health care system instead choose to participate in the new Veterans Choice Program, as established in the Veterans Choice Act and funded by section 802 of the Act.

- **Long-Term Services and Supports** estimate has increased by $51.1 million, reflecting trends in the most recent actuals and the continued investment into non-institutional settings.

- Ongoing health service programs not projected by the actuarial model increased by $221.6 million. The **Caregivers** program cost estimate increased by $249.4 million, driven largely by an increase in the projected number of Caregivers receiving stipend payments. The combined sum of the estimates for CHAMPVA, reimbursement to the Indian Health Service and tribal health programs, caring for eligible Camp Lejeune Veterans and families, and readjustment counseling decreased by $27.8 million based on updated actuals and revised assumptions in workload for Camp Lejeune and Indian Health Service.

- VA **programs to end Veteran homelessness** increased by $128 million, for a total of $1.393 billion. The increased estimate allows VA to fully support projected utilization in its homeless programs, including the Supportive Services for Veterans Families (SSVF) program and the Department of Housing and Urban Development-VA Supportive Housing program (HUD-VASH).

- **Health Care Infrastructure Enhancements** increased by $666.9 million. Facility **activation** costs have increased by $468.2 million over the initial advance appropriation estimate of $130 million to $598.2 million. The cost estimate of supporting the Veterans Integrated System Technology Architecture (**VISTA**) **Evolution** project has been revised downward from $208.3 million to $159.6 million. Estimated **non-recurring maintenance** obligations grew from $460.6 million to $708.0 million, to address high-priority emerging capital needs as identified through the Strategic Capital Investment Planning (SCIP) process; this increase excludes funding provided by the Veterans Choice Act. See Volume 4, Chapter 7 for additional information on the SCIP process and the NRM program.

- The cost of **VHA proposed legislation** remains nearly unchanged with an estimated cost decrease of $0.5 million. The 2016 budget includes estimates for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) healthcare benefits for beneficiaries up to age 26.

- **Additional budgetary resources decreased** by $84.4 million (collections, reimbursements and transfers). The estimate for the **Medical Care Collections Fund** decreased by $26.3 million. **Reimbursements** decreased by $51.0 million and transfers to the Joint DoD-VA Medical Facility Demonstration Fund increased by $7.1 million.

b. What metrics does VA use to ensure it is requesting the total amount needed for these initiatives when the budget request is sent to Congress?

Response. The FY 2016 advance appropriation funding level included in the FY 2015 Budget submission focused on providing essential initial funding for the advance appropriations year to ensure continuity of veterans' health care services. Each year, Medical Care funding, including funding for all non-modeled activities, is revisited during the budget process for the next submission and is revised to reflect updated information on funding requirements and budgetary resources, including unobligated balances.

Question 5. The budget request for the FY 2016 medical care appropriations and the FY 2017 advanced appropriations request include a cost shift of $452 million and $733 million, respectively, due to veterans using the Choice Program. Please explain the metrics used to determine the amount for FY 2016 and FY 2017 and the number of veterans it is estimated to provide care through the Choice Program.

Response. The Veterans Choice Program (VCP) may provide a measure of short-term relief from the pressure of escalating health care requirements as some current patients in the VA system elect to receive their care through the program. The 2016 and 2017 requests for the Medical Care appropriations assume that some veterans who would otherwise receive care in the VA health care system will now receive that care through the VCP, instead. This introduces a shift of health care costs from the discretionary program to the new mandatory source of funding in the Veterans Choice Fund, thereby reducing the discretionary appropriations request by the same amount. The assumed cost-shift is $452 million in 2016 and $733 million in 2017. These estimates were developed prior to having program experience and will need to be revalidated going forward.

Key assumptions that were used in the cost-shift model prior to program implementation:

- Consistent with the Regulatory Impact Analysis (RIA) for the Veterans Choice Program Interim Final Rule, we split the population into the two cohorts—(1) veterans living more than 40 miles from a VA facility (or meeting the other geographic criteria); and (2) veterans waiting more than 30 days for their scheduled appointment.
- In general, we used the same assumptions that were published in the RIA, wherever possible.
- One of the most sensitive factors involves the assumption about how many eligible veterans will participate in the VCP. It's difficult to predict veterans' behavior in response to this new choice, so we used a range of rates, from low to high.

As VA gains program experience we will revisit the methodology used to develop the cost shift estimate.

Question 6. During a House Veterans' Affairs Committee hearing on January 21, 2015, Deputy Secretary Gibson stated that the interim 90-day contract for the Denver VA Medical Center has been funded with $70 million. Please provide a detailed expenditure report for the $70 million, including when it will be depleted.

Response. This interim contract for $70 million includes a $20 million allowance to settle subcontractor liabilities, and $50 million for continued work on the project on a cost reimbursable basis. The $50 million is currently funding critical activities on the construction site. VA has added an additional $30 million for continued work on the construction for a total of $80 million. The $80 million is estimated to fund construction activities through March 29, 2015. If additional funds are not added to the contract VA will be forced to stop work on the site and begin to demobilize the contractor.

Question 7. VA indicated that the interim Denver contract will require an additional $300 million. Please provide a comprehensive list of the major construction projects that will have funds transferred to the Denver VAMC to pay for this increase and the specific amount taken from each project.

Response. The following table shows the source of the funding for the reprogramming actions to date:

Source	Amount
VHA Working Reserve (No Bid Savings)	$27,109,829
Physically Complete Projects (Bay Pines, FL—Outpatient Clinic (Lee County); Columbia, MO—Operating Suite Replacement; San Juan, PR—Seismic Corrections; Tampa, FL—Upgrade Essential Electrical Distribution System; Murfreesboro, TN—Psychiatric Care Facility)	3,897,215
Funds Transferred from Line items:	
Facility Security	8,401,000

Source	Amount
Asbestos	12,951,956
Judgment Fund	3,240,000
VBA APF	1,000,000
Total	$56,600,000

VA has not finalized which projects will have funds transferred to the Denver project to pay for the next increase which is projected to continue progress on the project until USACE has developed its cost estimate and entered into a long-term contract with Kiewit-Turner Construction.

Question 8. The FY 2016 budget request has TBD listed for the total estimated cost and future requests for the Denver VA Medical Center. Given that the facility has already had $825 million allocated to it, when will a new total estimated cost for the facility be complete?

Response. VA and the Army Corps of Engineers (USACE) are working collaboratively on the current short-term contract with Kiewit-Turner Construction, with the expectation of a long-term contract being negotiated by the USACE. USACE continues to develop a cost estimate to complete the effort and is tracking for a contract award summer 2015. As additional steps are taken USACE and VA will continue to update our stakeholders.

Question 9. For FY 2015, the West Los Angeles major construction project received a $35 million appropriation but was not authorized. The Long Beach major construction project received $101.9 million in appropriated funds but was not authorized. The FY 2016 budget requests authorization again for these projects, though it seems to reflect that the FY 2015 funds have been received and possibly spent. What is the status of the FY 2015 funds for the West Los Angeles and Long Beach projects?

Response. Congress did not pass legislation to authorize any of the major construction projects in FY 2015, including Long Beach, San Diego, San Francisco, West LA, and Canandaigua. VA is asking Congress to pass legislation to authorize these five projects expeditiously, in addition to the six new authorization requests for major construction projects are included in the FY 2016 Request.

None of the FY 2015 funds appropriated for the five projects have been spent, because the projects require authorization prior to obligation and expenditure.

The FY 2015 funds for West LA and Long Beach have been moved to the project. VA is awaiting Congressional authorization action before awarding a construction contract for either project. Currently, VA plans to make awards by September 30, 2015, subject to receipt of authorization.

Question 10. Women veteran gender-specific health care increased $34.3 million or 8.3 percent between FY 2015 and FY 2016. Please break out the amount allocated to each category included under gender-specific health care for fiscal years 2014, 2015, and 2016 as well as projections for FY 2017.

Response. See the following table.

$ Millions	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	FY 2017 Estimate
Woman Gender Specific Care	$380.0	$411.8	$446.1	$481.7
Category:				
Womens Clinic	$124.3	$134.7	$146.1	$158.7
Gynecological Exam	$59.0	$60.0	$61.2	$62.6
Pregnancy and Post-Partum	$52.8	$61.0	$70.2	$80.8
Female Genital Disorders	$47.9	$52.6	$58.0	$63.5
Breast Cancer	$29.6	$31.5	$32.8	$33.9
Breast Exam	$25.7	$29.9	$34.9	$41.1
Breast Disorders	$15.2	$15.9	$16.6	$17.2
Benign Neoplasm	$8.5	$9.4	$9.2	$7.1
Female Cancer Screening	$7.2	$7.7	$7.8	$7.8
Osteoporosis	$3.0	$3.1	$3.2	$3.3
Other Gender Specific Care	$6.6	$6.1	$6.2	$5.8

Question 11. What percentage of women veteran specific care is provided at VA facilities and what percentage is provided through non-VA care? Please break out

each category included under gender-specific health care for fiscal years 2014, 2015, and 2016 as well as projections for FY 2017.

Women Veterans: Gender-Specific Medical Care
(Share of total care provided at VA Facilities and by Non-VA providers)

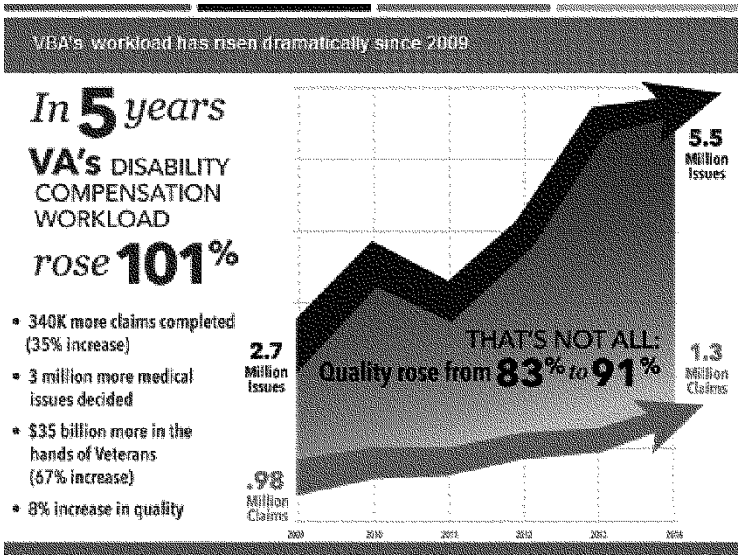
	FY 2014 Actual	FY 2015 Estimate	FY 2016 Estimate	FY 2017 Estimate
VA Facilities	69.7%	69.2%	68.8%	68.4%
Non-VA Care	30.3%	30.8%	31.2%	31.6%

Question 12. At a hearing before the House Committee on Veterans' Affairs on February 11, 2015, VA testified that there has been a 25 percent increase in productivity per employee with respect to claims processing.

a. Please provide the Committee with the details of how that statistic was calculated, including the number of claims completed per employee for the relevant time periods, the time period over which that change was measured, and the categories of employees that were included (for example, quality review teams, non-rating staff, appeals staff, fiduciary staff, management, etc.).

Response. The 25-percent increase in productivity is calculated by dividing the number of compensation and pension (C&P) claims completed in FY 2014 by the number of direct C&P full-time equivalents (FTE) in FY 2014, and then comparing this ratio to the same figure from FY 2012. In addition to claims processing personnel, Direct FTE includes all employees supporting C&P programs, such as fiduciary employees, national call center employees, outreach personnel, military services coordinators, etc. except for management support, which typically comprises 11 percent of all C&P field staff.

However, a more accurate representation of VBA's increase in productivity is at the issue-level rather than the claim-level. Calculating productivity by the more simplistic output of "number of claims" does not reflect the increase in workload VBA has experienced since 2009. From 2009 to 2014, VBA's productivity at the issue-level increased by 67 percent.



b. In calculating that statistic, were claims completed during overtime included in determining productivity per employee? If so, what percent of claims were completed during overtime?

Response. All rating-related C&P medical issues were included in the calculation of productivity per employee. Overtime has historically been an important management tool for VBA, although at levels generally lower than what has been used over

the past three years. In FY 2014, VBA estimates between 504,000 and 588,000 medical issues were completed due to overtime.

c. Please provide that statistic—productivity per employee—calculated in the same manner for the prior 10 years.

Response. The table below provides productivity figures per direct FTE at the issue-level since 2009. Issue-based data prior to 2009 is not readily available.

FY	Completed Claims	Issues Completed	Average Issues Claimed	Direct C&P FTE	Issues Per Direct FTE
2009	977,219	2,744,962	2.8	11,868	231.3
2010	1,076,983	3,808,712	3.5	13,555	281
2011	1,032,677	3,284,234	3.2	14,039	233.9
2012	1,044,207	4,128,321	4.0	14,119	292.4
2013	1,169,085	5,703,976	4.9	14,473	394.1
2014	1,320,870	5,528,656	4.2	14,307	386.4

d. If VA's FY 2016 budget is adopted, what is the expected productivity per employee during FY 2016 using the same manner of calculation?

Response. If the average number of medical issues per claim remains at 4.2 issues per claim, VBA expects productivity to increase to 397.5 issues per employee in FY 2016.

Question 13. Over the past few years, VA has used overtime to help process disability claims.

a. Please provide the amount spent on overtime for claims processing staff during FY 2014, the amount expected to be spent on overtime during FY 2015, and the amount requested for overtime for FY 2016.

Response. In FY 2014, VBA spent $132.9 million in overtime pay, including $122.8 million for the compensation and pension claims processing, $6.2 million for education claims processing, and $3.9 million on all other programs.

The FY 2015 budget request included $65 million for overtime, and at the start of the fiscal year VBA applied a portion of carryover funding to increase the overtime budget to $83 million. In January 2015, VBA reinstituted mandatory overtime for compensation and pension claims processing. To date, VBA has spent $40 million on overtime in FY 2015, including $37 million for compensation and pension claims processing, $1.9 million for education claims processing, and $1.1 million for all other programs. VA is assessing funding alternatives to sustain current levels of overtime for claims processing.

b. What portion, if any, of the overtime hours during FY 2014 were used to handle non-rating work or appeals?

Response. Eliminating the rating claims backlog remains one of VA's top priorities. Therefore, in FY 2014 and FY 2015, overtime has not been utilized to process non-rating work or appeals.

c. To date during FY 2015, what portion of overtime hours have been used to handle non-rating work or appeals?

Response. Eliminating the rating claims backlog remains one of VA's top priorities. Therefore, in FY 2014 and FY 2015, overtime has not been utilized to process non-rating work or appeals.

Chairman ISAKSON. Thank you, Mr. Secretary, and thank you for the timeliness of your remarks.

I will be brief in my questions, but to the point. In 36 years in legislative office, in one office or another, either in the State or the Federal Government, I have seen lots of consolidations and lots of reorganizations. More often than not, it means more government and more employees, less efficiency, and does not work. So, do you think consolidating the regions from nine to five will produce more efficiency and less burden in terms of employees?

Secretary MCDONALD. Yes, sir. Right now, the average employee at the lowest level working with veterans—and I have gotten this from the roughly 100 facilities I have visited so far—they feel they are a prisoner of a system that they cannot control. So, many of the ideas we are coming up with in MyVA are really the ideas of the employees who are trying to better serve veterans.

What they see today is there are nine lines of business. Each has their own geographic map. If you talk to one VA employee in one facility, they will not be able to direct you, largely, to the other eight lines of business. We have got to stop that.

MyVA is about reorganizing and getting more resources working with veterans. I do not expect it will be an increase in head count for the Department over time. In fact, I expect it will be a productivity improvement. That is one of the reasons we are going to shared services, where many companies have gotten significant benefit.

We plan to take those resources that we are able to gain through shared services and apply them for better customer service. Whether or not that reduces head count overall, I do not know yet, but our intention is certainly not to raise the head count of the Department.

Chairman ISAKSON. Well, I want to make sure the goal is achieved in improving services and unifying the VA and the VA employees but does not end up resulting in more payroll, more employees, and more bureaucracy. I think streamlining the VA is important to accomplish.

Secretary MCDONALD. Mr. Chairman, that is all of our goal.

Chairman ISAKSON. OK. On concurrent—I am going to show my ignorance here, show my memory loss in my older age—but, we changed concurrent receipt a few years ago because veterans with disability were not able to get retirement, is that not correct? And, we changed it to where if you had 50 percent disability or more, you were eligible for both the disability payment as well as your retirement, is that correct?

Ms. HICKEY. That is correct, Chairman.

Chairman ISAKSON. Then, if I look at this chart that you handed out about the average degree of disabilities increasing since 2000, that corresponds with the time we changed the law, if I remember correctly. So, by moving the eligibility threshold for joint receipt of retirement and disability to 50 percent disability determination, did that have a force effect to raise the number of determinations that were raised to 50 percent or higher?

Ms. HICKEY. I think, Chairman, the way I would answer that is there are multiple trigger points in the march up on the levels of percentage of disability. Certainly, at 30 percent, you achieve the opportunity to apply for dependency, meaning you get additional funds for having family members. At 50 percent, you get the access to health care. When you get upwards into the 70 percent marks, you start becoming more eligible for something called "individual unemployability," which raises you effectively up to the 100 percent. There are different threshold marks in there that are—where new benefits are triggered as a result of increases.

But, I will tell you that, clearly, in at least my data analysis, the number 1 issue that is driving the volume of work, that 5.5 million medical issues that you saw on the chart, is the number of medical issues that people are filing per claim——

Chairman ISAKSON. Right.

Ms. HICKEY [continuing]. Has dramatically increased.

Chairman ISAKSON. Well, I supported concurrent receipt and what we did, and I think it was the right thing to do, but I think

your answer confirms the fact that as you ratchet up the threshold to qualify for benefits, inherently, you are going to raise the cost of the services that you offer, and I am going to——

Ms. HICKEY. Chairman, I would also say, inherently, you are probably also meeting a need for a more disabled veteran that needs that need, as well.

Chairman ISAKSON. Exactly. That is exactly correct.

My time is almost up, so I will end with a comment. Secretary McDonald, I was delighted that in your entire presentation, which was not timed or limited, you did not talk about moving money from VA Choice to non-VA health care or to regular VA health care, which was originally a proposal you talked about. Is that still in the budget request?

Secretary MCDONALD. Mr. Chairman, the—I found a better way to articulate, I think, what I am talking about. What I am talking about, a choice. What we have done is we have implemented choice for the veteran, and what we want in VA is for the veteran to be able to make that choice. All I am asking for is flexibility that if the veteran does make a choice, that I have the funds available to be able to pay for their care so that we do not have what occurred in 2014.

We have over 70 line items of budget that do not allow us to move money from one line item to another. A company would never be run that way. Imagine at your home, if you had two checkbooks, one checkbook for gasoline, one checkbook for food. The price of gasoline falls by half while you are hungry and you need more food, but you cannot move money from the gas account to the food account even though that would be appropriate for your family. That is the situation we face.

We look forward to working with you and making sure you are totally aware of the data that we have so we can make sure the money is there for veterans.

Chairman ISAKSON. Well, you are moving in the right direction and I appreciate the articulation of the request.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you.

As I outlined earlier, Secretary McDonald, the Choice Card Program basically seems to be not working. I think you and I, in our conversations, have talked about the potential reasons that it is so underutilized. A small fraction of the veterans who are eligible to use it, in practical terms, are doing so. The 40-mile rule may be a cause. But, I wonder what the VA is going to do about it and what plans you have to act on the current real gaps and deficiencies in that Choice Program. We are now into the sixth month of a 3-year program, so there should be more to show for it.

Secretary MCDONALD. Let me try to address it, and then, also, if Carolyn has anything to add, she may want to add.

First of all, I would like to congratulate the Committee and the Members of Congress for the Choice Program. I think it is a great program. Even though we have been at this some time, we need to remember that the last cards went out in January and it is right now the end of February, so it is early yet. But, as the Ranking Member mentions, and we spoke about last night, we are working

hard to make sure we gather data to really understand and drill down into what is going on.

So far, we have gotten about a half million calls, but that has translated only into about 30,000 appointments or clearances. That seems like an awfully low ratio to us.

Second, we worked together to put in the geographic barrier as an allowance. It would allow the Secretary to allow someone to take advantage of the program. So far, we have only had less than 50 people take advantage of that.

Senator BLUMENTHAL. It is 44, you told me.

Secretary MCDONALD. Forty-four is the exact number. I said—we do not know exactly why, so we need to figure that out.

We are doing a number of things. One, we have gone back to our third-party administrators and we said, here is some new data that we need, because initially, we set up the relationship to give us data, but now we are discovering the data that we need to understand this situation. So, we are doing that. Hopefully, over time, we will better get that data, and then we will put together an algorithm that we will share with you and alternatives that will show how we should redefine that 40-mile restriction and reinterpret it so that more veterans can take advantage of the Act.

Senator BLUMENTHAL. But, if I may interrupt——

Secretary MCDONALD. Yes, sir.

Senator BLUMENTHAL [continuing]. You know, I think data is important, but meanwhile, the clock is ticking and real money was authorized for this program. So, I think there is a sense of urgency in the Committee. As I mentioned when you and I were talking, if this were a product at Proctor & Gamble that had a 0.37 percent purchase rate as compared to what you expected, if its marketing simply was not working, you would begin acting right away, and I hope that you will take——

Secretary MCDONALD. We——

Senator BLUMENTHAL [continuing]. Very strong and urgent action.

Secretary MCDONALD. I certainly agree with you. Hence, one of the things we have done is—we have got to do a better job of marketing the program. So, we are making calls. We are sending out brochures, and we have got a Public Service ad. I do not know, Mr. Chairman and Ranking Member, if you would like to see it, but we have posted an ad that we recently created which is already out there on YouTube getting hits right now——

Senator BLUMENTHAL. I have seen it, and I would like to see it again, but not on the time that I have for questioning.

Secretary MCDONALD. OK, sir. [Laughter.]

Senator BLUMENTHAL. Let me go to——

Secretary MCDONALD. Anyone who wants to see it, we want to make sure that you get the opportunity.

Senator BLUMENTHAL. Let me quickly go to——

Secretary MCDONALD. And, put it on your own Web sites, please.

Senator BLUMENTHAL. Sorry, again, for interrupting——

Secretary MCDONALD. That is OK. No, no.

Senator BLUMENTHAL [continuing]. But, I want to be respectful of my colleagues' time. The Inspector General—the budget actually requests an amount of funding that would reduce the number of

full-time positions, which I think is unacceptable. We have yet to see the Inspector General report on the debacle that inspired the Choice Program. That delay, in my view, is inexcusable. I requested that the Federal Bureau of Investigations be involved, because I said at the time that the Inspector General lacked sufficient resources to do a prompt and effective job—nothing personal or professional about his qualifications, but resources, as I know from my law enforcement experience, are critical. To increase the budget by so small a factor, 0.3 percent, where there is actually a reduction in full-time positions, I think, is unacceptable. Would you comment.

Secretary MCDONALD. Yes, sir. You are right. that was an administrative error. We have gone back and talked to the Inspector General, and when he testifies in front of you, he is going to ask for a $15 million increase. We support him 100 percent on that. Right now, we have got a number of investigations that are ongoing, and the sooner we get these done, the happier we all will be.

Senator BLUMENTHAL. Finally—I have a lot more questions, but very little time—on the issue of medical research, particularly into mental health, my understanding is that there has been no requested increase for that research. Am I correct?

Ms. TIERNEY. For mental health, I will have to check, but overall, the research budget goes up $33 million in our 2016 request.

Senator BLUMENTHAL. Well, for the VA's National Center for Post Traumatic Stress Disorder, which, as we all know, is the signature wound of these 13 years of war, the funding is stagnant. For centers like the Health Care System Medical Care Center Campus at Westhaven, which is doing enormously promising and critically important work, to leave this funding stagnant, in my view, again, is unacceptable.

Ms. TIERNEY. Yes, sir. I think Dr. Clancy can probably better address this. When we ran the model, we found that we are having less very seriously injured people in the war coming back and our costs are stabilizing in that arena, but let me turn it over to Dr. Clancy.

Senator BLUMENTHAL. Well, if I may say, with all due respect, your injuries may be stabilizing because you are not recognizing them——

Ms. TIERNEY. Thank you.

Senator BLUMENTHAL [continuing]. And acknowledging their existence. The military itself says that 30 to 50 percent of our returning and separating men and women suffer from these invisible wounds of war. We just passed new law, the Clay Hunt SAV Act, recognizing the importance of providing mental health care. The research into how to treat it is even more important, or at least as important as providing funds for the treatment, because we are now using pharmaceutical drugs that are actually counterproductive, according to the experts in this area. So, may I suggest respectfully that the research funds be increased for this purpose.

Chairman ISAKSON. Thank you, Senator Blumenthal.

I might interject, since mental health was raised, I want to congratulate VA on the recognition they received at the Academy Awards for the VA Mental Health Hotline. I think you have made

a major move forward in getting the VA accessibility to someone in a state of crisis, and you are to be commended for that.

Secretary MCDONALD. Mr. Chairman, we would love to share that video with anyone who wants to see it.

Chairman ISAKSON. There is going to be a time, but it is going to be after everybody has their questioning.

Secretary MCDONALD. I am sorry. I meant the HBO program.

Chairman ISAKSON. Oh, OK. Good.

Senator Moran.

STATEMENT OF HON. JERRY MORAN,
U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you very much. Thank you for your opening statement as well as Senator Blumenthal's.

Mr. Secretary, nice to see you again. I was thinking that in the time that you have been the Secretary of the Department of Veterans Affairs, I have had more opportunity to have conversations with you than any other Cabinet Secretary. I appreciate that. I will see you in the Appropriations Committee on this topic again in a few weeks. Yet, I do not feel like the circumstances that I keep explaining and expressing concern about are being expressed.

Therefore, the problem is that while I have more time to speak to you than I have had with any other Cabinet Secretary, I must be failing in my ability to deliver the message that I want to deliver because I have no doubt that you care about the results that I am seeking. So, I am going to try one more time to express to you as the Secretary, and to members of your team, where I think we are still failing in hopes that my communication skills this time are sufficient to get change at the Department.

You would expect me to talk about the 40-mile issue, and I will, but it is broader than that. What troubles me, and again, I know you have been in office a short period of time, but I will tell you, the complaints that I receive from veterans in Kansas about the quality of the service, the timeliness of their being seen by a physician, their ability to access care, is no less today than it was a year ago.

I would tell you that the success of claims, that while your numbers indicate that the length of time for which claims over 125 days are pending is improving, the number of veterans who come to me, to my staff, asking for helping with a long pending claim is no different.

I worry that we are setting the stage for another kind of scandal, similar to the one about the fake list, the waiting list, because your numbers are affected by claims that are being appealed. And, I think one of the things that is happening at the VA is, while you have shortened the number of claims that are pending, they are now just in a different category, waiting appeal, and the end result is our veterans are still waiting.

There is no sense of the employees at the Department of Veterans Affairs that I visit with in hospitals and facilities across Kansas, that there is any more direction from the Department of Veterans Affairs in Washington, DC, directed to them and how to manage their operations, or any more freedom to make decisions at home than there was before. In a sense, there is no change that

emanates from Washington, DC, so that folks who are on the front line of delivering care to veterans feel like they know better what to do or have flexibility to make the decision about what they should do.

There is no sense, to my knowledge—I mean, you can convince me—that there has been accountability since the scandals of a year ago, that we are still waiting for the Department of Veterans Affairs to handle employees who conducted themselves inappropriately, perhaps illegally.

When I raise topics of concern about a specific veteran in a setting like this, my veteran gets attention, which I appreciate, but I can tell you, as soon as the spotlight is over, that veteran is back to the same position he or she was in before I raised their claim with the Department of Veterans Affairs. So, they get a moment of reprieve, but it does not last.

Further, Mr. Secretary, when it comes to the 40 mile issue—that background, I hope, suggests to you where I am coming from in my skepticism about the Department's implementation of the Choice Act—and 40 miles is a significant component of that, but not the only aspect. It is not just the 40 miles, within the 40 miles, and it is, I do not know, 42 Senators that are in this. I am not the mile guy. Forty-two Senators sent you a letter indicating our preference about how this should be implemented and related to—this is Senator Collins' letter—related to as the crow flies as well as to whether a facility that does not provide the service that a veteran needs should be counted as a facility. The problems are beyond—in the implementation of the Choice Act—are beyond just that 40-mile issue.

When a veteran signs up—and you indicated a half-a-million veteran calls—the problem is, when they call, they are often told they do not qualify. "You are not on our list." But, then, there is nothing the veteran can do about it to say, "Wait a minute. I should be. I am." There is no appeal process for a veteran who should be on the list to get on the list.

You are requiring prepayment of copayments, causing veterans to pay more money for their health care if they choose the Choice Act, in a sense, discouraging that choice.

In addition to that, trying to get community providers signed up for services—I have been trying for months to get community mental health centers to be able to be one of the providers of those services—unsuccessfully. We have a provider who says, "I am going to lose money, but I have decided I want to do this, but I cannot get the VA to even approve me to be a provider under the Choice Act."

So, the concern I have is that the VA has a mentality against outside care, even in the circumstances where one cannot get service within 30 days or within 40 miles, and that is highlighted by—just a couple more points, Mr. Chairman—that is highlighted by the fact that when we attempted to implement the ARCH Program, the VA was not at all interested in seeing, in my view, its success. In fact, we came across an e-mail from the VA in DC instructing the VA in Wichita not to promote, market, or encourage participation in ARCH, suggesting to me that there is this approach or attitude against outside care.

Finally, Mr. Secretary, while you have been available, and, in fact, you asked Deputy Secretary Gibson to come see me, the President's budget request—you are going to artfully change your words a bit today, and I appreciate that—but, the suggestion that the money could be used for higher priorities within the VA is troubling to me because it, again, demonstrates the lack of interest in this program.

When Deputy Secretary Gibson came to see me, he told me we could not do the 40 miles because we could not afford it. Now, I am told we need to move the money out because it is, in a sense, not a priority. But, then, I will tell you, a few days later, Dr. Tushman was in our office indicating that the only cost estimates of the Choice Act were on the back of a napkin. We do not have the information to determine what the costs are.

So, we are told it is expensive by the Deputy Secretary. We are told by the number 2 person at VA health, we do not really have numbers.

I try to be very optimistic, and all this is couched in terms of I thought and want great things to happen with your arrival at the Department. I thought Congress finally got its act together. We actually could function. Republicans and Democrats come together and pass a piece of legislation that has value and I want to see its success.

Mr. Chairman, thank you.

Chairman ISAKSON. That was over time, but that merits a response.

Secretary MCDONALD. It does. I am going to try to do the best I can, Senator Moran. If I am missing something, let us get together later and talk about it.

We are for the Choice Program, and we are for outside care. Over the last 12 months or so, we have had roughly 500,000 appointments in outside care which is up 48 percent—not Choice but outside care. So, we already have a process for outside care. The difference is that this is outside care we suggest to the veteran, not that the veteran suggests to us.

So, we already have a culture of outside care, and while I cannot say every employee would tell you that outside care is a good thing, I can tell you the leadership believes that it is the only way to go. We have got to have a combination of VA care and non-VA care to properly care for our veterans. There is no question about that.

When the law was passed and the law was designed, nobody knew—and, arguably, as we talked with the Ranking Member—we still do not exactly know how many veterans are going to choose to use it. So, we are in a period of uncertainty, but we are trying to get as much certainty as we can so we can go back as quickly as possible and change the definitions of the 40 miles, change the definitions of the geographic barrier, in order to get more people in the program. We want more people in the program, and I think if you see our public service ad, you will see demonstrated that is our intent. Yet, we have got to figure out why they are not there. And just like you would in marketing anything, we have got to figure out how to get people in.

So, we want to get people in, but if the situation exists that they do not go in, all I am saying is that at some point we will share

with you how many people are in. We will do the best we can to get them in. But, if they do not go in, what we do not want to do is lose the budgetary flexibility if those people stay in VA, because we made assumptions as to how many people would leave VA care, and we took that money out of the VA budget. That was the only point I was making. It is a point of flexibility.

Relative to facilities in Kansas, I need to get there. You know, as you know, I gave out my cell phone number publicly. I get calls, I get e-mails, I get texts every single day. I am seeing a change. I am still getting a lot of complaints, but I am seeing a change. The Veterans Service Organizations are telling me they are seeing a change. But if you are not seeing a change in Kansas, that does not do the people in Kansas any good. So, we will get out there, and we will take a look. We will work with you.

Senator MORAN. Mr. Secretary, thank you for working with me. We would love to have you in Kansas. I look forward to your support of the 40-mile-fix legislation that I know the Chairman has visited with you about.

And the final thing I would say is that when Secretary Shinseki resigned, one of the things that stuck with me in his comments was, "I was too trusting of some, and I accepted as accurate reports that I now know to be misleading." Make certain that what you are telling me today is backed up by facts as you can know them, not by the culture or the circumstances that you find with the people that surround you.

Secretary MCDONALD. Yes, sir. I would like to invite you and other Members of the Committee to join us for our daily stand-up, which is where we go through all of our data. We had the Ranking Member and the Chairman there, and I think you would find it to be very helpful.

Chairman ISAKSON. I think we have already got a date set in June for the next opportunity for a town——

Secretary MCDONALD. I am thrilled. Let us do the stand-up and the town hall together. That would be great.

Chairman ISAKSON. In fairness to all the Members, I am very liberal with the gavel because the questions and the comments have been excellent, but there is a point of patience that I will use to——

Senator MORAN. I feel sufficiently chastised, Mr. Chairman. [Laughter.]

Chairman ISAKSON. I started with Mr. Blumenthal, and you just added on.

Senator Brown?

Senator BROWN. Thank you for starting the new impatience rule with me, Mr. Chairman. [Laughter.]

HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Secretary, and thank you for your outreach and your accessibility. We have all commented on that and all appreciate that.

We spoke yesterday about the Ohio NPR affiliate which raised health concerns related to post-Vietnam dioxin exposure to reservists who flew or worked on C–123 aircraft, as you know. They do

not fall under the Agent Orange presumptive eligibility construct. I want to acknowledge the VA's efforts regarding the *Institute of Medicine*'s recent report. Can you assure me that this will happen? And give us the timetable, if you would.

Secretary MCDONALD. Yes, sir. We asked the Institute of Medicine to do that analysis. The analysis came back positive. We have looked at it, and we have looked at ways to identify the people, and we are expecting to make an announcement next week. Gen. Allison Hickey, Under Secretary of Benefits, will be making that announcement next week.

Senator BROWN. OK. Good. Thank you.

The Department I know has made ending the claims backlog by the end of this year a priority. My growing concern is that expediting claims processing has led to an increase in veterans filing appeals to their claims, which in turn makes dealing with the backlog more difficult. The Cleveland regional office, as we have discussed, continues to have a backlog numbering in the thousands of claims. The budget request has $85 million to hire 770 new staff.

Could you walk us through what will happen with the new staff, what their function will be, how quickly this happens, and how it affects the backlog?

Secretary MCDONALD. Yes, sir, I will; plus I will ask Allison to comment. I want to just give a short overview.

If you remember, when we put in our request for the Choice Act, we had people in the Choice Act that would work in VBA to work on claims and to work on non-rating claims, which is part of the backlog issue. When the Choice Act was passed, that was stripped out. We have had people working mandatory overtime in order to get more and more claims done. We have also converted most of the claims now to digital, and as a result, we are able to have a national work stream.

We are at the point where we really need the people if we are going to continue to make progress against the claims and the appeals.

Allison?

Ms. HICKEY. Let me just start by very quickly giving you all a larger update since we last met. The inventory for all of our claims is down 45 percent. The backlog is down, this morning, 64 percent, from 611,000 to 222,000. The quality is up 9 percentage points, up to 92 percent at the claim level, and at the medical issue level 96 percent. Believe it or not, despite the fact that there are a volume of appeals increases, not the rate; the rate has remained steady for more than 20 years. In fact, last year it actually went a little bit lower, but not enough that I am going to statistically quibble anything about that. But it has held steady at 11 percent.

But remember the chart that we showed you where we did 9 million versus 1.3 million record-breaking—or 900,000 4 years ago versus 1.3 million this last year, which is record-breaking for us; 11 percent against 1.32 million is many more.

Here is the situation for appeals: despite the fact we have increased our production against it by 35 percent last year, we still have two solutions to appeals. One is change the law. I recognize there is little appetite for it, but I have submitted the legislative request regardless. The second is throw a whole lot more people at

it. So, those are the only two provisions I have, neither one of which I control. Why? Because it is so wired, this appeals process is so wired in law. It is not like the claims process where I could do 45 initiatives to drive that excellent takedown in the claims backlog. I cannot do it.

There is one idea out there—and I am extremely appreciative to the VSOs, specifically DAV who took the leadership, and all the rest who signed on, for the fully-developed appeals process. That will help at the margins. It still requires a legislative fix, which we will need that in order to proceed forward.

But at the end of the day, beyond that, two things will fix the appeals process—legal changes to it or a whole lot more people—and we have submitted that in this budget. There is in this budget request for appeals, for non-rating, and for fiduciary, all—which was a byproduct of a successful increase in production and productivity as a result of the transformation.

Senator BROWN. One last brief question, Mr. Chairman. I know from representing you in the Senate that P&G is one of Ohio's great companies in labor-management relations, which was always so important to you and that you honored your workers and labor—union and non-union alike. I have been very impressed with your reaching out both to AFGE and other unions, their leadership and rank-and-file. My question—and we all welcome your comments at the beginning of your testimony in terms of upgrades and new construction and modernization of the physical facilities. My question is simple: will you continue to utilize project labor agreements in VA construction, in all VA construction?

Secretary MCDONALD. I am not an expert in that topic, but if—you said "continue." If we have been doing it, certainly we would. I have reached out to our labor union leaders, and I have spoken at their national conventions. I honestly believe—65 percent of our employees are union members. We cannot get this change done without the employees leading it, because who better to know what we need to change than those working with veterans every single day? As a result of that, we have a very strong relationship with J. David Cox, the AFGE president, and others. We are working hard to do that. We will get back to you on that.

Senator BROWN. OK. Thank you for that.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. SHERROD BROWN TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Yes. VA is required to determine, through market research and Impact Studies, if Project Labor Agreements (PLA) are appropriate for construction procurements at or above $25 million. When beneficial, VA provides the option for contractors to submit a proposal with PLA and/or without PLA.

Senator BROWN. One more point about that. The unions—the AFGE and the other VA unions you negotiate with and work with are not typically the unions that my question would be involved with. These are construction trades that actually build the facilities, as you know from expansions at Procter & Gamble over the years. I appreciate your track record on this. I just want to see it continue, and I want to see it everywhere. We had some problems in VA before about the pay of workers, the unionization rate of

those workers, and I think it affected the quality of construction. I know how much you care about that.

Secretary MCDONALD. I need to dig into that more. I will learn from it and get back to you.

Senator BROWN. Thank you.

Ms. HICKEY. Senator Brown, if I can make one more comment; Cleveland is doing phenomenally well. Their backlog is down 80 percent. Their quality is up into one of the highest in the Nation at both claims level and issue level.

Senator BROWN. Thank you.

Chairman ISAKSON. Senator Cassidy.

HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Thank you. Clearly, patient access to care is important. You have impressive statistics about the total number of visits. Are no-shows—when somebody has an appointment scheduled but does not show up—are those included in your total number of visits?

Secretary MCDONALD. Yes, but I want—you are making a great point. No-shows is a really big issue.

Senator CASSIDY. So, really, we cannot interpret the number of outpatient visits you list unless we know the percent of those in which the patient did not actually show up. Do we know the percent of those total number of visits?

Secretary MCDONALD. Yes. I was going to say, one of the things we review every morning is the no-shows.

Senator CASSIDY. So, what is that percent of total visits which are "no-shows?"

Ms. HICKEY. It depends on the facility and the type of appointment——

Senator CASSIDY. I totally accept that. That is my next question. Globally, what would you say of the—I think you had 80—some incredible number. What percent, 20 percent, 10 percent, 30 percent?

Dr. CLANCY. I would say it is probably more in the ballpark of 20 percent. I was literally on the phone with a physician the other day from the great State of Montana, I might note, who said that actually they had started calling and had reduced it quite a bit. He was orthopedics, down from thirty——

Senator CASSIDY. I get that. So, the next question is: are these generally distributed throughout the system and institutions? Or can you pinpoint institutions in which these no-show rates are particularly egregious?

Dr. CLANCY. It is not quite that pinpoint-able. Interestingly, veterans who come from rural areas have a much lower no-show rate, and the more rural, the highly rural have the lowest no-show rates; rural a little bit higher than that, and urban actually have——

Senator CASSIDY. Now, let me ask, because when you mentioned your daily stand-up of looking at data, really, unless you can bring it down to "This facility has a no-show rate of 30 percent, not improving, and this one has 30 percent but is down from 50, and this one was 10 but now it is 30." The same 30 percent rate has far different meaning in that context. So, I am asking, in your stand-up meetings, are they worth—and I do not mean to be disrespectful,

but unless you are able to interpret it in that means, what value are they?

Dr. CLANCY. No. That is exactly what we are working on with facilities, and I think as the Chairman and Ranking Member can tell you, the day they came we actually had one facility online. We had two lined up, but we ran out of time. And that is the kind of deep dive that we are doing with facilities to help them figure this out. We also have some electronic tools to help them.

To get back to your initial question, we look at both pending appointments as well as completed appointments, so we are actually reflecting on the completed appointments who showed up.

Secretary MCDONALD. This is the chart, Senator Cassidy. It shows missed—we call it "missed opportunities." And as Carolyn says, it breaks it out by rural, urban, highly rural—I am sorry Senator Moran is not here—and it also breaks it out by specialty. And as you can see, as you would expect, mental health is——

Senator CASSIDY. Is that in here?

Secretary MCDONALD. No, sir. This is our daily stand-up——

Senator CASSIDY. My eyes are 57 years old, man. I cannot see that.

Secretary MCDONALD. Well, come on over. We would love to go through this with you and get your advice.

Senator CASSIDY. Sounds great.

Dr. CLANCY. We would be delighted to give you a briefing.

Senator CASSIDY. Now, once I sat on a plane next to someone who—a physician, who told me he was in charge of a "turnkey operation" in which the VA contracted for him to go, I think, to the Thibodaux area in Louisiana. It was an outside group. They set up all the nurses, all the docs. They rented the space, started seeing patients, and they were held accountable for quality by the VA. Poor quality, boom, you are out of here. Poor turnover, boom. But good, you stay. Now, I have not seen him since, do not know if that clinic is still turnkey. But do we have a sense—if that is a model VA uses, do we have a sense of both the no-show rates in those clinics versus the VA traditional facility and the productivity of those clinics versus a regular facility? I see Ms. Tierney nodding her head.

Dr. CLANCY. We have about 850 community-based outpatient clinics, or CBOCs, and then we have a couple hundred that are contract. My general impression is that the quality and timeliness has been variable in those contract operations, and we are actually looking into that right now. I would be happy to follow up with you.

Senator CASSIDY. If you could, because it really—I mean, the question is: do you have a model where there is accountability by contracts and you lose the contracts if you fail to perform, whether that is better than a traditional VA model? Our endpoint is not preservation of VA. Our endpoint is preservation of the veteran, and so we need to look for that best model.

Dr. CLANCY. Absolutely.

Secretary MCDONALD. We are going through that now. We believe we have to take responsibility for wherever the veteran gets the care.

Senator CASSIDY. Now, there has been a lot of talk about the veteran's electronic medical record (EMR). Do you have a sense of the average time a physician in the VA system spends entering data per clinic visit? Because, obviously, I think Epic says it is 17 minutes per visit, which is obviously not the time you are looking into the veteran's eyes to find out if he or she is depressed. So, do you have—you do not have that?

Secretary MCDONALD. I do not have it with me, but we will get it and get it to you. We certainly look at that, and certainly as I go around to our different facilities, I hear our providers talk about the need for people to put that data into the medical record.

Senator CASSIDY. I get you. I will tell you that talking to my physician colleagues, I get a sense that they spend a lot of time on your EMR and not as much time looking into the eyes and saying, "Are you depressed?"

Secretary MCDONALD. That is true, but for benefit of the other Committee Members—because I know you know this—the EMR also signals questions that the doctor should ask. If, for example, a doctor wants to prescribe a drug, the record might say back, "Well, watch out, the compatibility of that drug with another drug"——

Senator CASSIDY. So, next, can I finish up? Because the Chairman was so generous with time. There is a GAO report on the improvements needed in monitoring antidepressant use for major depressive disorders and increasing accuracy of the suicide data that I am sure you are familiar with from November 2014, showing major deficiencies in the VA's database as regards veterans suicide. I think I heard a report, but I am saying it off the top of my mind, 22 veterans commit suicide a day. That may be an overstatement. I am saying it off the top of my head.

Now, here they found a number of deficiencies in data collection. Theoretically an EMR would have done it automatically, but indeed it does not. Can I ask you specifically what is being done to address this issue?

Dr. CLANCY. We have follow-up plans with the facilities and networks that have the greatest opportunities for improvement. An EMR can remind clinicians what is the right thing to do. As you probably know from your own practice, there is no guideline or recommendation that is 100 percent right for 100 percent of patients. So, what we are trying to figure out is to what extent are people making appropriate decisions and to what extent are they actually just not paying attention.

Senator CASSIDY. This is also about data collection, though, for example, date of death being wrong on the form as to the day the veteran committed suicide, as just a simple sort of, "Man, somebody did not do this right" sort of thing.

Dr. CLANCY. Yes.

Senator CASSIDY. I am over time. Thank you very much. Thank you for your service.

Chairman ISAKSON. Thank you, Senator Cassidy. It is nice to have a doctor on the Committee.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Mr. Chairman, thank you very much, and welcome to all of our witnesses. Mr. Secretary, it is really good to see you again. I do have an opening statement I would like to submit for the record.

Chairman ISAKSON. Without objection.

Senator MURRAY. Thank you.

[The prepared statement of Senator Murray follows:]

PREPARED STATEMENT OF SENATOR PATTY MURRAY

Mr. Chairman, thank you for holding this hearing.

A budget is a statement of our values and priorities. And as the daughter of a World War II veteran, I believe making sure our country keeps the promises we've made to our Nation's heroes should be at the top of our list of priorities, all of the time. Taking care of our veterans when they come home is a fundamental part of who we are as a Nation.

It is part of the cost of going to war. And making sure the VA has the tools and resources it needs to provide care and support our veterans is critical.

I was very pleased to see the President submit a strong budget request for VA this year. In particular I am pleased to see VA requested an increase of $34 million for gender-specific health care for women veterans.

Also, I continue to hear from veterans about delays in processing certain types of claims in the Seattle Regional Office, so VA's request to hire another 770 employees nationally to help bring down those processing times is very important.

However, the President's budget request also includes areas where we are not investing strongly enough. With the continuing high rates of suicide among veterans, and long wait times, we need to increase funds for mental health care. I am also concerned that the request for the IG is insufficient. Especially at this critical time when so much oversight of VA hospitals is needed, we cannot afford to cut the Office of Inspector General, which has been so vital in making sure veterans get the timely, quality care we expect.

Even with an overall strong budget request, effective management and oversight is critical to the Department providing for our veterans the way we expect.

Mr. Secretary, from your experience in the private sector you know as well as anyone here how difficult it is to change the culture of a large organization. But change is essential. VA has struggled with these types of efforts in the past, so you certainly have your work cut out for you to make sure this time we are successful.

You are asking the right kinds of questions—how to move the Department's focus from the bureaucracy to focus on the veteran's experience—and taking a fresh look at how business services are delivered. Human resources, contracting, I.T., and construction have all been major problems for the Department for many years. I hope you will stay focused on how to bring real reform to those offices.

Mr. Secretary, I am also looking forward to working with you on some important legislation to improve the health care services for our veterans.

I recently introduced S. 469, the Women Veterans and Families Health Services Act, which will expand critical fertility services to injured and ill servicemembers and veterans to help them realize their dreams of having a family when they otherwise might not be able to because of an injury in the line of duty. And I was very pleased to work with Senator Heller to introduce S. 471, the Women Veterans Access to Quality Care Act. That bill would greatly improve access to gender-specific care for women veterans, and ensure VA is accounting for the needs of the growing population of women in the construction planning process.

Implementing the Veterans Access, Choice, and Accountability Act will also be a critical issue this Congress. The $5 billion we gave to build and strengthen VA for the long-term is already making a difference. In my home state of Washington, two medical centers have already announced they will hire a total of 324 new medical care staff in the Puget Sound and Portland/Southwest Washington regions.

As for the Choice Program, I understand there are some initial problems implementing the program, and I hope you will act quickly to resolve them. But it's also time to start planning now for what the future of non-VA care will look like.

There are now several different major authorities VA can use to purchase care outside the system. They are often duplicative and inefficient, and they are not consistent with each other.

The Choice Program was a temporary, emergency authority. When it expires, VA needs to have a reformed program in place to help veterans access care outside VA in a way that: complements services provided by VA, provides coordinated care with strict quality of care requirements, has consistent processes and eligibility rules, and is cost effective

Finally, I would also like to thank our representatives from the veterans service organizations. Your hard work each year, especially on the *Independent Budget*, is very important for us as we work to make sure there are adequate resources to provide veterans the benefits and care they have earned.

Thank you, Mr. Chairman.

Senator MURRAY. Secretary McDonald, as you know, and you said in your opening statement, the population of women veterans is increasing dramatically. It has doubled since 2001. I was really pleased to work with Senator Heller to introduce the Women Veterans Access to Quality Care Act to make sure that the VA does have the services and facilities to meet the needs of women veterans.

One of the key provisions of that bill is requiring obstetrics and gynecology to be available at every medical center. I wanted to ask you what resources and staff, including support staff, will you need to meet that kind of requirement.

Secretary MCDONALD. Thank you, Senator Murray. We are very much in favor of that approach. We are in the process of putting women's clinics all over the country. We have a new one here in Washington, DC, and I would like to invite the Members of the Committee to visit it. It is in our Washington, DC, facility. It is a women's clinic.

As you know, I have been out to about 12 medical schools, talked to deans. We are hiring and we need to hire more gynecologists.

Senator MURRAY. Do you know how many you would actually need to do this?

Secretary MCDONALD. The exact number? I do not have an exact number. I can tell you that in the past 9 months or so, we have hired about 8,000 people. Of that, about 1,000 are doctors, but I do not know how many of them are gynecologists. We can get back to you with that number.

Senator MURRAY. OK. If you can get that back to me.

[The information referred to follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. From April 1, 2014, to March 31, 2015, VHA's net onboard for providers was over 1,017 physicians (4.5% increase). Of those, 13 were gynecologists (11.7% increase).

Senator MURRAY. I also wanted to bring up that the VA policies—it is way past time to bring the VA policies up to date with modern medicine and allow the VA to provide better fertility treatment, including in vitro fertilization, for seriously injured veterans who want to start a family. This is a high priority for me. I think it is a high priority for our veterans, and I want to work with you to get that done, as well. So, I will be talking to you more about that.

Secretary MCDONALD. We are working on that.

Senator MURRAY. OK. I want to hear from you, what are you doing to work on this?

Dr. CLANCY. My staff briefed me recently in terms of how many women might be eligible and what would be the specific requirements——

Senator MURRAY. Well, it is women and men.

Dr. CLANCY. Yes. And also compared what the Department of Defense covers versus what we cover, or actually do not at the moment. So, I sent them back with some more questions, which we would be happy to follow up with you.

Senator MURRAY. OK, and I will submit some questions on this, but I think this is absolutely critical for our men and women who serve overseas and lose their capability, then we have to make sure they can start a family. So, I will be focused on this.

I also wanted to talk to you about the legislation that I introduced last year to expand the caregiver support services to VA, to all eras of veterans. I am going to be introducing that again this year, and I want to be sure we are all working together to strengthen that program so it will be ready to take on the additional workload.

VA's budget request says that in fiscal year 2015 you cannot hire any new caregiver support coordinators to help with the overwhelming demand, and I hear already at some facilities that providers refuse to help with doing initial evaluations or home visits. To me that is just unacceptable. I wanted to ask you what you are doing to bring in more caregiver support coordinators.

Secretary MCDONALD. Let me start, and then I will ask Carolyn to comment.

We are very much in favor of improving our caregiver operation. In fact, in the last week, I met with Senator Dole of the Elizabeth Dole Foundation. We are working very closely with her.

First, what we have agreed to do is to set up a special advisory committee for the Secretary on caregivers. We do not have that, and I think we would benefit greatly from having that—working with her, incidentally, working with her foundation.

Second, we are talking about having a caregiver summit, something where we could get everybody together, and we are working together——

Senator MURRAY. For all eras or just——

Secretary MCDONALD. All eras. All eras, because, again, Post-9/11 is not enough.

Senator MURRAY. Yes.

Secretary MCDONALD. We want to work together with you on this.

Senator MURRAY. OK. Well, I want to stay in touch with you on that. Please keep me up to date on what they are doing.

Finally, I want to talk to you about a homestate issue, the Spokane VA emergency room. They have seen a dramatic cutback in operations simply because of staffing problems. I have to tell you, as the daughter of a World War II veteran, this is unacceptable to me. It is a very serious problem for veterans in that area, and we have got to get it back to full-time operation. I wanted to ask you today, When will the emergency room at the Spokane VA start operating 24 hours a day again?

Dr. CLANCY. Senator, we have had significant recruiting problems. We had originally hoped to open it to 24/7 in April, and it

is now looking like that is going to get pushed back a few months. However, I met with some colleagues from the American Legion just a couple of days ago at their meeting, and they have actually been out speaking to some of the other hospitals in town who may be able to help us out.

The other area where we need help, I think, recruiting emergency physicians is a legislative change that would allow us to accommodate what many people who go into emergency medicine want, which is greater flexibility for hours than the current Federal H.R. policies allow.

Senator MURRAY. OK. Are you looking at every option? Because we——

Dr. CLANCY. Yes.

Senator MURRAY [continuing]. Have heard recruiting forever. So, temporary providers, bringing in doctors from other facilities, absolutely everything, because this is a critical need in that community.

Dr. CLANCY. I would agree with you, and we are looking at all options, yes.

Senator MURRAY. OK. I want to follow up with you on that so, let me know when and how and when we are going to see that open again.

Thank you.

Chairman ISAKSON. Thank you, Senator Murray.

For the benefit of the Members, the order for questions will be Sullivan, Tester, Rounds, Sanders, and Hirono, unless somebody who was here comes back. Anybody argue with that? Is that OK?

[Nodding in agreement.]

Senator Sullivan?

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman.

Mr. Secretary, your team, thanks for your testimony today and your service. You know, I think there are a couple things going on here that give a sense of frustration from the Members on some of the big issues that I know you are working hard on, and it goes without saying that in many ways it is just a strong passion all of us feel in a very strong, bipartisan sense. You have the disabled vets in town all week, and you see that, you see what they have sacrificed with regard to our country. It is hard not to get passionate about this. I know you guys are passionate about this and, as you can imagine—you and I have talked about it—in Alaska we are quite passionate about it. We proudly wear the title of the State that has the most veterans per capita of any State in the country.

A lot of what Senator Moran talked about I share in terms of the frustration. And you mentioned getting out to Kansas. I would welcome a commitment from you to come visit Alaska, given, you know, our challenges there. While we were just on recess, I was actually out in our new veterans' facility there on Joint Base Elmendorf-Richardson, and had a briefing from your team, which was quite informative. They did an outstanding job.

We would love to get a commitment from you to come visit our great State this year, if possible, with your team and look at some of those issues.

Secretary MCDONALD. I would love to visit Alaska. I served there and I would love to come back.

Senator SULLIVAN. OK, Outstanding. Then we will do that.

I wanted to also follow up on the appeals process. You know, a big issue that I think would be helpful in terms of your team testifying in front of this Committee, if you can give us a very regular update on the backlog, both in terms of the existing backlog and the appeals. You know, I think in many ways that has been kind of a symbol of some of the challenges, some of the problems. You can put a finger on it in terms of the numbers, and I think there is concern in the Committee of kind of having that bulging backlog kind of just move over to the appeals.

Ms. Hickey, I know you were talking about the express appeals process. I know a number of us are looking at legal ways in which to move that. You mentioned that it would just possibly move on the margins. We do not want to move on the margins. We want to address this in a fulsome way.

Can we get your commitment to work with us on what would be some of the ideas that we are working on to address that? We do not want the backlog to be kind of a whack-a-mole issue. That would be very devastating, I think, for our veterans. It is really important that we put a lot of smart minds, not just money but minds, to this. I would like your commitment on working with us on that.

Ms. HICKEY. Senator, I am more than willing to give our commitment. We have done that repeatedly. And we keep thinking about solutions. We have new, fresh minds to bring to the table as well. This is one that will require the Congress' active participation——

Senator SULLIVAN. Good.

Ms. HICKEY [continuing]. Because of what I have described, which are issues that are beyond our control.

Senator SULLIVAN. Great. Then we will—I know that the Members of this Committee are very interested——

Secretary MCDONALD. Senator Sullivan, may I also add that we will work with your staff on this. We put our data online every 2 weeks, so it is open to Members of the Committee, and we are doing that for a reason. I know there have been questions about our data, but it is online every 2 weeks. Your staff can get it and download it, and you can call us and ask questions. We are trying to be as transparent as possible.

Senator SULLIVAN. OK, great.

Ms. HICKEY. And in this case, I will tell you actually our data is up every Monday. It is in the Monday morning workload report. Congress last year asked us to add appeals information to that. We did. It is in there. And I also have numbers of VBA stat sessions that we run every month, which I would invite you or your staffs to participate in some of those. We do very deep dive data conversations with our RO directors and go through each and every line of what they are doing and their performance.

Senator SULLIVAN. Great. We look forward to working with you on that.

I have two questions, and they are for you, Mr. Secretary. You know, when you and I talked, you mentioned that the budget of the VA has increased pretty dramatically over the last several years.

I forgot the number. I think you said something along the lines of 60 percent over the past 6 years. That may be a ballpark figure. So, my two questions are—and they are unrelated, but I just want to get them in under the buzzer here so I do not get reprimanded by the Chairman.

First, given your background, do you think the problems are money versus culture? I mean, you can throw money at an organization, drown it in money, but if you do not have the culture to solve the problem, you are never going to solve the problem.

Second, you talked about in your budget how we could end veterans' homelessness. The term "homeless veteran" is a term that I just choke on. I hate the term. I would love to get rid of it in the English language. If you have a plan on ending veteran homelessness, we are all ears.

Secretary MCDONALD. Well, let me go for homelessness first. We are committed to ending veteran homelessness by the end of this year. We do have a plan, and the plan is putting veterans in homes first. There is not a lot of debate about this any longer. The science in homelessness now is getting the veteran in a home first and then providing all the treatment for them. If you do not get them in a home first, you run into Maslow's hierarchy of needs kinds of issues. It is best to get that out of the way. Get them in a home. We have programs to do that. We have several programs, more than a dozen programs to do that.

The most important thing is community involvement. That is the reason I went out to Los Angeles. I ended a lawsuit that we had there. I got the community together. Everybody has a role. We in the Federal Government can provide a HUD-VASH voucher, but if we do not have a local landlord willing to rent at that rate, we cannot get the veteran in the home.

Senator SULLIVAN. Got it.

Secretary MCDONALD. So, it requires a 360-degree solution. We know that we can do it. The mayor of New Orleans committed to end homelessness, and in 6 months we had done it.

Now, admittedly, there are not as many people homeless in New Orleans as there are in Los Angeles, but we know we can do it and we know how to do it. We would be happy to work with you on it.

Senator SULLIVAN. Great. Thank you.

Secretary MCDONALD. I forgot the second——

Senator SULLIVAN. Culture versus money.

Secretary MCDONALD. Culture. Obviously, culture is the most important thing. In my leadership experience, the way we are approaching this is we have got to change the culture. We have to change the systems, if you know what I mean by—the repetitive processes, because many of our employees feel like they are prisoners of a system that is not right. We have to change the strategies, and we are doing that.

Partnerships is a strategic change; and we have to change leadership. Over 90 percent of our medical centers have either new leaders or new members of the leadership team.

In fact, what I worry about as I am trying to go out and recruit is all the bad press that we are getting; it makes my recruiting job very difficult. And, if Congress is to pass laws that affect VA employees only, it makes my recruiting job even more difficult.

We are trying to show that we have a plan, there is a good reason to join us, and we are getting a lot of takers. As I said, our employment is up. So, we are making progress.

Senator SULLIVAN. All right. Thank you.

Thank you, Mr. Chairman.

Dr. CLANCY. May I make one addition from your State.

Chairman ISAKSON. Quickly, if you will.

Dr. CLANCY. Yes. In the short term we do need resources because a lot of our clinicians, who are terrific, are actually limited to one room per clinician, which means that affects productivity and how many veterans can be seen and so forth. So, I was thinking about the Nuka system in Alaska which has been a huge inspiration for us, but we believe that some part of their success was their ability to create a very, very different space. MyVA and the shared services that the Secretary is bringing about will help us get to a place that we can do that more efficiently and expeditiously.

Chairman ISAKSON. Senator Tester.

HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Yes, thank you, Mr. Chairman. I want to thank the Secretary and your team for being here today.

I have been particularly proud of this Committee, to serve on it, and particularly proud of the work the previous Congresses have done. When I first got here, you had discretionary funding in the VA; now it is mandatory. You had year-to-year funding; now we have got forward funding. We plussed up the budgets. We have had some great Secretaries from Peake to Shinseki to yourself, and I appreciate that. And to add to that, in Montana, I will tell you, you have some great people on the ground. The veterans who get through the door love the health care they get for the most part. There are a few exceptions to that. And the reason they love the health care they get is because of the health care professionals that are on the ground. They like it better than the private sector. That is why you do not see a lot of referrals out because they want to see their doc within the VA.

That being said, we have got a problem, and that problem has to do with vacancies. The Director for VA in Montana had been an Acting Director for so long that he is no longer there because the Acting Director time ran out, 240 days. It is a huge issue. We have talked about it multiple times before. It is parochial in nature, but I think it is bigger than that. I think it happens in far, far too many regions. In fact, Dr. Clancy and Mr. Walters are Acting.

When can we see a full-time Director in Montana? And when can we see nominees for the two positions Dr. Clancy and Mr. Walters have?

Secretary MCDONALD. We are hoping to get the full-time Director in Montana within days.

Dr. CLANCY. I was just checking my e-mail. We are actually expecting some word today, so——

Senator TESTER. Word today?

Dr. CLANCY. Yes.

Secretary MCDONALD. We were hoping to have it by——

Dr. CLANCY. We have a great candidate. That is not the issue. It is some paperwork that is beyond VA.

Senator TESTER. OK.

Secretary MCDONALD. I also have worked with the President. We have nominations coming to the Senate very shortly. You will probably get some nominations next week.

Senator TESTER. OK. That will be good.

You had talked in your opening statement, Mr. Secretary, about antiquated infrastructure, the fact that we need new buildings, which I agree with.

At Fort Harrison, we have a new acute psychiatric wing. I was there for the grand opening. Dr. Clancy's predecessor was there when we cut the ribbon on the tape. Everybody was happy about it. It was going to take care of issues that dealt with PTSD and alcoholism and drugs. That facility—"closed" is not the right word, but it is not taking any patients; a fact, we have been dealing with. A disabled vet with PTSD was turned away because that facility was no longer accepting patients. The county spent $2,400 to send him—but the bigger problem is that the facility was built—it is brand new, yet we do not have the staff. You just said hiring is up. You have got the best staff in the country in Montana. Why can't we get some people to Montana to help these folks out? Why can't we get that facility open?

Secretary MCDONALD. I am hoping to learn more about that when you and I go to Montana, and I am hoping during our trip we can do some recruiting.

Senator TESTER. I appreciate that. The problem is that I do not know—we talked about culture, we talked about money. I think you guys are great. I think the people you have got on the ground in Montana are great. What is going on in the middle? Why don't we have aggressive recruitment going on with the folks down in Denver, in our region, and regions in the country?

Secretary MCDONALD. They are aggressively recruiting.

Senator TESTER. I do not see it.

Secretary MCDONALD. But we do not see it in your result, so I have to get into it and learn about it.

Senator TESTER. OK.

Secretary MCDONALD. Make a difference.

Senator TESTER. All right. I have a question. There is a group out there—it is my understanding a group called "Concerned Veterans of America"—that is putting forth a proposal today to reform the VA, among other things. It would restrict the VA to only service-connected veterans. Could you give me your thoughts on that?

Secretary MCDONALD. Well, as you know, the Department of Veterans Affairs is committed to providing veterans the best care they can get. They have earned it, and we want them to get it wherever they want, whether it is in the VA or outside the VA. The veteran is the core of our mission, and it is fundamental of our purpose of MyVA, the reorganization we are doing.

Unfortunately, many of the proposals that are coming up today advocate contracting out what we consider to be a sacred mission of those who have borne the battle. So, it is important—we think there is an important role for outside care in veteran health to supplement our own VA care. But, frankly, we do not think that should diminish or obscure the role and the importance of VA's health care program. That is what we worry most about. Reforming

VA health care cannot be achieved by dismantling it or by preventing veterans from receiving the specialized care and services that can be received only from VA.

Our goal continues to be to provide timely, quality care and benefits, and we want to work to improve access, wait times. We want to find partners to help us. But we do not want to dismantle the VA.

Senator TESTER. One last question, if I might, Mr. Chairman. I need you to provide me an update of the situation in Tomah VA medical center in Wisconsin. It is not my State, but it is very, very important. It is my understanding that Senator Baldwin had asked you for a VA investigation last June. It is also my understanding that the VA waited until January to launch that investigation. Why?

Dr. CLANCY. The Inspector General actually delivered a report to the facility last spring and essentially told them not to share the report with anyone, so we did not have awareness of that for a number of months later.

Senator TESTER. Why would they do that?

Dr. CLANCY. They subsequently published it on February 6, and they did not find very much to act on. They had reviewed the practices of some clinicians whose practices were reported to be under concern. They simply did not come up with any hard findings to act on at that point in time. But, we did not have awareness of that until sometime in January.

I am told that sometimes they close reports when it is more or less a negative report. I am just trying to explain the timeline. Right now we have completed the first phase of an in-depth clinical review with a second phase that has just launched, and the Office of Accountability and Review is also vigorously evaluating reports of retaliation and bullying by this one physician, who also happens to be the chief of staff. The clinicians in question are not seeing patients. They are on administrative detail, and they are also not able to prescribe any kind of medications for patients.

We are taking this very seriously. We are reinforcing our effort systemwide to promote the safe and effective use of opioids. You want pain management, but at the same time we know that opioids come with a very big price tag in terms of side effects. So, we are not waiting for all the investigations to be done to be able to move forward on improvements we can make right now at Tomah and elsewhere.

Senator TESTER. Fifteen seconds. I have been on this Committee since I got to the Senate. I believe in the people who serve this country, just as Senator Sullivan talked about. We have great service on the ground, but I am more concerned today than I have ever been in the past about what is going on in Montana's VA, and that is what I am most familiar with. We have got to do better. I think everybody on this Committee is here to help you do better, but something is wrong. I am telling you because it is a good outfit; people should want to go to work there.

Thank you.

Chairman ISAKSON. Following up, I want to thank Senator Tester for bringing up the Tomah issue. For the record, so everyone

knows, the House Committee is going to Tomah, as I understand it—is that not correct?

Dr. CLANCY. Yes.

Chairman ISAKSON [continuing]. On a site visit, and we are trying to coordinate with them to do as much outreach as we can. Our second hearing after the hearing on the 40-Mile Rule will be on Tomah and on the overprescription of opiates.

With regard to the IG, I have great respect for the IG. I think the IG provides a tremendous benefit to the Committee. But, that benefit is only utilized when we have the reports. I had the same question the Senator raised with regard to why those reports were not in the hands of the Committee as well. I will be working with the IG to see to it we have more transparency on those reports for the Members of the Committee. We may have to embargo them for reasons that you mentioned, Dr. Clancy. But I think it is important that the Committee know and not get caught by surprise.

Secretary MCDONALD. Mr. Chairman, may I make a very brief comment? Concerning the report that is going to come out today that you asked about, Senator Tester, I have not gone through the details of the report, but I also want to—my statement is not—I want to make sure that you know that I am reaching out to a member of that committee to try to find out what there is to learn about it, and I am open to any ideas anybody has. So, I just want to make sure that you understand we are open to other people's ideas.

Chairman ISAKSON. Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman.

I would share that we had a very good meeting yesterday with the South Dakota delegation and I appreciated your time and your efforts in visiting about the Black Hills facilities, including the hospital at Hot Springs. First, I want to just briefly touch on that issue and then I would like to delve into a couple of other items.

First of all, would you be able to assure the Committee that the items in the fiscal year 2016 budget request regarding the Black Hills Health Care System are not an indication of a pre-determined decision for the Hot Springs Hospital?

Secretary MCDONALD. Yes, sir, Senator Rounds. As we talked yesterday, the money that was in there for Rapid City is what we need to do at Rapid City. There is no indication of any decision being made on Hot Springs. I have made no decision. We are still collecting data and the study is still being done, and that is why we met with you.

Senator ROUNDS. Thank you, sir.

Look, I have listened as each member around here has invited you to come in, and I know that we have talked about coming to South Dakota. You have got more things on your plate than I can imagine, and yet there seems to be kind of an underlying current here, and that is that you have stepped into a position in which you have got a huge and very unwieldy agency/administration. You have started with a reorganization, and you have got MyVA, and I notice that you have got some charts laid out for us in here.

When you take a look at the organizational chart that you have inherited—I had one of your employees come up to me and lay out what they had kind of charted out. They had 13 layers that they had been able to count. You cannot run an organization that has got that kind of a program. So, number 1, it looks like, what both Senator Tester and Senator Sullivan are talking about, the issues way down deep, they suggest that it is culture. I kind of go a little bit deeper and think that you can have real good people working in an organization, but if the organizational system, the layout, the map for getting approval and so forth and making changes does not work, you can have good people that just get frustrated and pretty soon, they do not want to be there. You have got folks on the ground, doctors that do a great job with individual veterans coming in, and yet the frustration that they have with trying to get changes made that they think would make it better, they become part of the issue that you are walking into.

Can you talk a little bit about the organizational structure and what you would like to see done; what progress you have been able to make with regard to the organization; and how that may impact the ability for those folks that are at ground level to be able to respond.

Secretary MCDONALD. Your insight is absolutely right. As I went around to the roughly 100 facilities I have been at, the number 1 feedback I get from the lowest-level employee is, "I am a prisoner of a system I cannot change." So, what we are trying to do is change the culture. We are trying to empower people to know that they can create change.

We have stood up teams across the country that have people with similar interests in working on various issues. We are teaching them Lean Six Sigma technology so that they can make changes to the processes they work.

Second, I have met with all the union leaders and I have said—65 percent of our employees are unionized—that it is their job to help us empower these people, and they have all been right on with that.

Third, one of the things we do not do well is we are not a connected organization. We have vertical silos in our nine lines of business, but we also have horizontal silos, if I can say it that way. That is one of the reasons we had to go from the nine geographic maps, as a first step, to one. That is a big enabler. Now, we can take on other things that we could not take on. All of these things have to be sequenced.

The next point would be that in addition to changing the maps, it is important that we change the organizational structure. Today, when I go to the human resources leader of VA and say, I would like the names of our top 50 development candidates, she cannot produce that because our functions are not connected from top to bottom in the organization.

Senator ROUNDS. It does not work.

Secretary MCDONALD. Companies do not run this way. So, we have got to build those connections in. We are in the process of doing that.

I am as frustrated—we are as frustrated as all of you are that it takes time to create these changes, because the changes all have

to be sequenced; and we have to make sure the employees are involved in creating those changes, that it is just not top-down, because we have got to get at the stick.

I am bringing in the very best people I know from the private sector to help us. We brought a Chief Customer Service Officer in. We have brought in a person to work on strategic partnerships. I am setting up an external advisory board, and you will recognize many of the names on that board. They are people who have done this before in the private sector. It is all going to accelerate our process and our progress.

Senator ROUNDS. Can you give me a timeline?

Secretary MCDONALD. I wish I could. We are going to make substantial progress in the next year.

Senator ROUNDS. OK.

Secretary MCDONALD. I think in the next year, you are going to be able to—I do not think there will be anyone who will not see the progress. And, you certainly will not be seeing the same structure we are in today.

Senator ROUNDS. Thank you.

Secretary MCDONALD. You are welcome.

Senator ROUNDS. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Rounds, very much.

The record should note the patience of former Chairman Sanders. I appreciate your patience, and it is now your time for questions.

HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Senator SANDERS. You are going to give me 15 minutes for that, right?

Chairman ISAKSON. I am not that appreciative, no. [Laughter.]

Senator SANDERS. Thank you, Mr. Chairman. Let me also thank the Secretary and his staff for being here.

A funny thing happened on Tuesday. The Chairman and I and other Members of the Committee were there to hear testimony from the DAV, who do an extraordinary job representing disabled veterans. Well, it turns out that when I asked Commander Hope of the DAV his views about VA health care, what he said is that, by and large, the care was very, very good. In fact, he thought, representing his membership, that it is probably better than private care.

So, the first point I want to make is that you run 151 hospitals. I suspect in every single one of them, there are problems today. I suspect on any given day, the media will put those problems on the front pages. You run 750 CBOCs. You run Vet Centers. You have 6.5 million people coming in a year. And, if you had 90 percent satisfaction, you would have a hell of a lot of people who would be dissatisfied. So, you run an enormous operation.

But, I think it is fair to say, in my view, talking to the service organizations, that, by and large, given the context of health care in America, which has enormous problems, that the VA does a pretty good job for those folks who get into the system.

Let me go on the record as to suggest—this is no great secret that we live in a political world—there are some very conservative organizations who do not believe in government. Some of them are

funded by the Koch Brothers. They do not believe in Social Security. They do not believe in Medicare. They do not believe in the VA. They want to dismember the VA.

Let me go on record to tell you that I will fight any effort to dismember the VA, because I think when you talk to the veterans of Vermont or the service organizations all over this country, as I do often, they say, you know what, there are problems—and I share the concerns that all Members here have raised, as we want to make it a better system—but, by and large, you have got a pretty good, cost-effective system.

Number 2, in the bill that Senator Isakson and I and others worked very hard on, we put $5 billion into, in fact, strengthening the VA. Now, what I am hearing from you and from other members, you are having a hard time recruiting physicians, and you know why? Because in this country—forget the VA—we have a huge crisis in primary health care physicians. I was told—Jon Tester told me something I never knew. He explained that in Montana, and I suspect in other rural States, in some hospitals they do not have any doctors? I had never heard that in my life. In Kansas, you have that problem, I believe, Senator Moran, right? It's unbelievable.

Now, one of the things that I insisted be in that bill is debt forgiveness to make it possible to recruit doctors. Tell me what you are doing, and the difficulties that you are facing—and it is not just you, it is the Nation—and if you think it is bad today, it is going to be a lot worse 15 years from now. So, what are we doing to get young people out of medical school into the VA and into primary care, for example?

Secretary MCDONALD. You are absolutely right. The debt forgiveness provision in the Choice Act is a huge enabler, and the debt provision in the Clay Hunt Act is a huge enabler. What we have done is we have made sure that our recruiting team is going out and talking about that. I can tell you from the roughly 12 medical schools I have been to—you and I were together in Vermont—that this is making all the difference in the world. It is a huge enabler. The average medical school student, my understanding, graduates with about $150,000 to $180,000 in debt. The Committee and the Congress doubled the former VA debt forgiveness, so it is making a huge difference. It is one of the reasons November was our peak recruiting month. So, we are getting better and better as we get the word out.

Senator SANDERS. But, my point is, this is not just a crisis for the VA. This is a crisis for the United States of America. All right.

Issue number 3. In the last 2 years, I think the major concern is that many veterans were on horrendously long waiting periods, all right. In fact, that precipitated a major crisis within the VA. How are we doing in shortening, if we are, the waiting periods? We do not want veterans to be waiting in lines for months. Are you making any progress on that?

Secretary MCDONALD. Wait times are down about 18 percent nationally, and on average, are roughly 30 days. But, of course, that is an average, and we have wide variation, as you can imagine, by location and by specialty. Anything you want to add?

Dr. CLANCY. I think one big, big point that has changed, Senator Sanders, is that we are literally looking at data almost on a daily basis to identify, as one of your colleagues pointed out earlier, where there are very specific problems; what we can do about that. One of the big assets we actually have is a very large footprint in telehealth. So, when Denver had huge problems in mental health waiting times, Salt Lake City could step in and help them bring those wait times down.

Senator SANDERS. What about Phoenix?

Dr. CLANCY. Phoenix is improving. In fact, we were hoping to make a visit with the Chairman and Senator McCain literally tomorrow, but we are going to have to postpone that because of other Senate business here, but look forward to doing that. We have a very good Acting Director in there. We are recruiting hard for a permanent——

Senator SANDERS. But, we are making some progress——

Dr. CLANCY. Absolutely.

Senator SANDERS [continuing]. In some of the worst areas of the country. You are focusing on those——

Dr. CLANCY. Yes.

Senator SANDERS [continuing]. Where the waiting times were the longest.

Next, let me concur with Senator Murray about the caregivers program. I think Congress several years ago developed that program for post-9/11 veterans. I think sometimes, Mr. Chairman, we forget that there are people out there, often wives, sisters, others, family members, who have devoted a large part of their lives to taking care of disabled veterans. So, we made progress. I would hope that we expand that program and I hope you, Mr. Secretary, will work with us.

Another area where I think we need a lot of work, we have in this country not only a primary health care crisis, we have a dental crisis. It is a huge issue. Right now, you do dental work for service-connected veterans, and I, when I was Chairman, went around the country and talked to a lot of folks. There is a need, I think, to expand that program. Would you comment on that, Dr. Clancy or Mr. Secretary?

Dr. CLANCY. You are right that we only provide dental services to a very small proportion of the veterans that we serve. We are looking at partnerships. We also have a low-cost dental insurance product that we have made available. But, we facilitate veterans getting access to this—it is a kind of partnership—and would be looking to expand in any way that we could work with you on.

Senator SANDERS. OK. The last point that I would make, we have talked in this Committee a lot about opiates and the side effects that opiates have. The VA, I think, has been—along with the DOD, actually—leaders in this country in terms of moving to complementary and alternative medicine. Dr. Clancy, can you give me a report on that very briefly? Are we expanding the program? If people want to come in and get acupuncture, meditation, yoga, are they able to do that increasingly?

Dr. CLANCY. Yes. First of all, we are expanding that, period. Second, as part of the issue of pain management and adaptation, oftentimes for a number of veterans, those modalities are very help-

ful augmentations and help some veterans actually transition to lower doses or actually off opioids altogether. It does not happen instantaneously. But, I can tell you that we are now looking at the practices of individual clinicians and teams so we know where we can provide the most assistance, who is having the most challenges. We have got some virtual training that has demonstrated some phenomenal results in Ohio and we are planning to spread that out elsewhere.

Senator SANDERS. All right. Thank you very much, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sanders.

Senator Hirono.

HON. MAZIE K. HIRONO, U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman, and Mr. Secretary, it is good to see you again.

I have a couple of questions relating to the Choice Card Program. I realize that there are some communication issues regarding that card with the veterans who receive them not quite understanding what it means, so I expect that you are addressing those kinds of issues.

I did have one matter that was brought to me regarding the veterans who use the Choice Card when they go to see an outside doctor for a brace or a durable medical device, there is a catch–22 there, because the VA has not updated their policy and only issues items like a knee brace to veterans who have an order from a VA doctor. So, even if they get to an outside doctor who prescribes such items, they cannot get them. So, are you making the necessary changes so that the veterans can get the prosthetics and other devices that they need?

Secretary MCDONALD. I was unaware of that problem, so I would like to—we would like to follow up with you and get into that——

Senator HIRONO. Thank you.

Secretary MCDONALD [continuing]. And make sure we address it.

Senator HIRONO. I realize that the VA is the second-largest department in the entire Federal Government and so there are huge complexities involved in the challenges that you are facing, so I want to add my support to what you are doing to change your culture, to change your organizational structure. I realize it cannot be easy with the thousands and thousands of employees that you have, so I commend you, all of you, for the efforts that you are undertaking.

When I met with you, Mr. Secretary, you said that eliminating veterans' homelessness is a top priority and that you expect to eliminate homelessness among veterans by the end of this year. You are working in particular with 25 identified cities where there is a high veteran homeless population, Honolulu being one of them. Can you describe particularly how you are doing it, including—by the way, I think you mentioned the HUD-VASH voucher program, but the new budget that was submitted, I think, does not set aside vouchers specifically to address veterans' housing. So, that may have a negative impact on your ability to get the veterans into housing in these cities.

So, could you just describe for me what you are doing. For example, in Honolulu, you are working with the mayor of the city and county. What is your expectation of what he is supposed to be doing?

Secretary MCDONALD. The most important thing from our side is our medical center directors need to know those mayors and partner with those mayors. They cannot wait for me or for Carolyn to go out there to do it. So, we have asked every one of our medical center directors to make sure they are partnering with those mayors and working with the mayors to make the commitment to end homelessness by the end of this year.

Then, we are bringing the tools to bear. You have mentioned a couple of them. The HUD-VASH vouchers is one tool. Another tool is a wonderful program called SSVF, which is about supporting families. We had—we need some work by Congress to—we had about half-a-billion dollars in the budget for the SSVF program. Only $300 million of it was authorized. We need the other $200 million to be able to complete the program. So, we will be working with you on that. But, that is a wonderful program. It allows us to work with a local partner in order to get the families into housing, and it is the local partners that become very important.

So, those are the steps we are taking. I have not been to Honolulu yet in this capacity, although I have been there many times before, and always enjoyed it——

Senator HIRONO. I extend the invitation.

Secretary MCDONALD [continuing]. But, I would—the issue that we are seeing is, for example, I was with the Mayor of New Orleans the other day. We were holding a conference here and we were teaching mayors how to get this done and we acknowledge one of the things that is a problem is if you have a good climate, chances are good when you house the homeless veteran, you are going to have more homeless veterans because they are going to good climates. As a result of that, I worry a little bit about Honolulu——

Senator HIRONO. Yes.

Secretary MCDONALD [continuing]. Places like Honolulu, New Orleans, Los Angeles, San Diego. So, I would like to get together with you and talk more about this.

Senator HIRONO. I believe that Hawaii has the highest per capita number of homeless, not just veterans——

Secretary MCDONALD. Not just veterans——

Senator HIRONO. Yes. That is an issue.

You mentioned, regarding homelessness, that it is a whole community approach. So, do you have some kind of a media program that you are running that says to a community like Honolulu that we are all coming together to eliminate homelessness in our communities?

Secretary MCDONALD. Yes. In fact, we have a road map, a plan, that we work with each mayor and community on. That was what I was doing in Los Angeles. We had a press conference. I did a "Meet the Press" segment on that and the work that we did. So, yes, that is part of the plan, and we can sit down with the mayors that you want us to and go through that plan.

Senator HIRONO. I am wondering if there is a PSA or something that can be shown in all of these cities. Do you have such a thing?

Secretary MCDONALD. Yes. That is a great idea.

Dr. CLANCY. I guess that I would just build on the Secretary's leadership in striking a deal with partners in Los Angeles, because we are planning to use that as a model that we can then export lessons learned. So, we need people at our facilities working very hard to meet the veterans' health care needs and so forth and reaching out to make sure that they get the right kinds of supportive services. But, we also very, very much need community partners. So, we have got a terrific individual leading this effort in Los Angeles with the idea that he will then bring those lessons learned rapidly to the other cities facing the greatest challenges, because the Secretary has made it very, very clear there is no way that we accomplish our stated goal in 2015 of getting close to functional zero without a renewed effort, stepping on the gas, if you will.

Senator HIRONO. Thank you.

Ms. HICKEY. And, Senator, if I might add, it is not just the health. It is an all of VA response, because I have two rather significant pieces that would contribute to the homeless mission. One is the very biggest program on prevention that exists out there, which is related to our Home Loan Guarantee Program. In the last 4 years, we have kept 400,000 veterans and servicemembers from foreclosure. So, we have kept them in their homes by interjecting up front, as soon as we see—because we are in a paperless environment, we can see the data, see you have missed your mortgage payment, hear from a VSO or from you directly that you are in trouble—we immediately throw our great loan guarantee folks at that problem and see what we can do to renegotiate the loan, keep you in your home. That is the ambition of that.

Senator HIRONO. Thank you.

Ms. HICKEY. The second thing is, in our claims process and in our appeals process, we have provisions for expediting homeless veteran's both claims and appeals. We do that rather regularly and that is another way we try to get additional resources into their hands by the nature of what we can do on the claims side or on the benefits side.

Senator HIRONO. Thank you.

Secretary MCDONALD. May I add one more, Mr. Chairman, Senator Hirono, because I am really glad you are on this topic: Veterans Courts. A ticket to a homeless person means incarceration; so what we are working to do is set up Veterans Courts all over the country so that we avoid incarceration. We know that if we avoid incarceration, we avoid homelessness. So, this becomes another breakthrough for us to stop veterans' homelessness.

Senator HIRONO. Thank you very much. Keep up the good work. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Hirono. On that point, that is another place where we have far more vacancies than we need right now, because the importance of coordinating with a Veterans Court for that veteran is critical and that communication needs to be seamless and timely between the VA and the judge in charge of that court.

As you can evidence by both the attendance and the longevity of the questioning and the quality of the questioning, there is no

agency of the government that has more challenges to meet than the VA. I think I speak for the entire Committee, although only one Member is left here with me right now, and that is to say we have your back. You have our support. But, it is neither timeless nor unlimited. Now that we have isolated the problems before us on Choice, on facilities, on flexibility in funding, all the things you have talked about, it is time for us to put our shoulder to the grindstone and get the job done. We will not let the detractors tear us down nor let the protractors protract it out, but instead work together to improve the VA and make the VA better than it has ever been before.

With that said, we will go to our second panel. This hearing is not adjourned, but we will have an intermission.

Secretary MCDONALD. Thank you, Mr. Chairman.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. In response to pre-hearing questions regarding the analysis performed to determine whether the 5,006 new full-time equivalent (FTE) employees under the Medical Support and Compliance account are needed as opposed to whether the duties could be performed as ancillary duties of existing employees, the Department of Veterans Affairs (VA) stated:

> The Medical Support and Compliance FTE growth is not associated with the Secretary's MyVA initiative.
>
> The additional positions are being added to the Medical Centers and [Veterans Integrated Service Networks (VISNs)] to support and fulfill the Secretary's vision of becoming a more *Veteran-centric organization* and to be able to *provide top-level customer service* in a more efficient manner to our Veterans. These personnel will support healthcare workers in order to deliver the healthcare services that our Veterans expect.

(Emphasis added.)

On December 18, 2014, VA briefed staff on the MyVA initiative. According to slides handed out at that briefing, MyVA is about:

> [E]mpowering employees and helping them *deliver excellent customer service* to improve the Veteran experience * * * [and] rethinking our internal structures and processes to *become more Veteran-centric* and productive.

(Emphasis added.)

a. Please describe the analysis performed to determine whether the 5,006 new FTE under the Medical Support and Compliance account are needed as opposed to whether the duties could be performed as ancillary duties of existing employees.

Response. The Medical Support and Compliance (MSC) full-time equivalent (FTE) growth is not directly associated with the Secretary's MyVA initiative.

VA medical centers and Veteran Integrated Service Networks (VISN) are adding additional MSC positions to support and fulfill the Secretary's vision of becoming a more Veteran-centric organization and to provide top-level customer service in a more efficient manner to our Veterans. As a result, some of the following positions will be increased: personnel management specialist, police, contract administrator, voucher examiner, claims assistant, emergency management series, medical records clerk/technician, health systems specialist, administrative officer, and security clerical and assistants . These positions directly support the Department of Veterans Affairs' (VA) objective to manage and improve VA operations to deliver seamless and integrated support. The additional personnel will support the delivery of health care services that our Veterans expect. Though not originated as part of MyVA, the FTE growth will improve the service VA provides to Veterans, and will therefore support MyVA efforts.

Although the FY 2016 Revised Request estimate of 54,020 FTE is 5,006 more than the original FY 2016 Advance Appropriation estimate, it is only 1,206 more than the FY 2015 Current Estimate. As displayed in the table below, VA anticipates growth in FY 2015 Medical Support and Compliance FTE. The FY 2015 Current Estimate of 52,814 FTE is 3,800 more than the FY 2015 Budget Estimate and 2,491 more than the FY 2014 Actual FTE. The FY 2015 Current Estimate is largely based on FTE Operating Plans submitted by the VISNs, and reflects a concerted effort to

provide more support staff to VA clinical staff in order to enhance Veterans' access to health care. The FY 2016 Revised Request increase of 1,206 FTE above the FY 2015 Current Estimate is a 2.3 percent increase, which is in line with VA's estimated increase in health care demand.

Medical Support and Compliance FTE

	FY 2013 Actual	FY 2014 Budget Estimate	FY 2014 Current Estimate	FY 2015 Budget Estimate	FY 2016 Adv. Approp.
FY 2015 Budget	48,610	49,929	50,303	49,014	49,014

	FY 2014 Actual	FY 2014 Actual	FY 2015 Current Estimate	FY 2016 Revised Request	FY 2017 Adv. Approp.
FY 2016 Budget	50,323	50,323	52,814	54,020	55,300
Change from Estimate	394	20	3,800	5,006	
Change from Previous Year	1,713	1,713	2,491	1,206	1,280

b. Please describe, in detail, the difference between the MyVA initiative as it was defined to staff on December 18, 2014, and the duties to be performed by the 5,006 new FTE in Medical Support and Compliance.

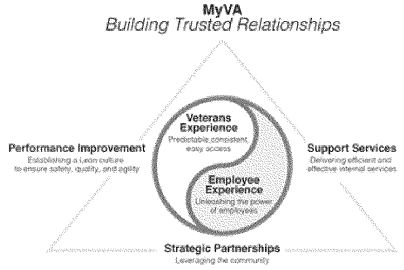
Response. The requested Medical Support and Compliance (MSC) resources would focus exclusively on medical centers and VISNs. Though not originated as part of MyVA, the FTE growth will improve the medical support VA provides to Veterans, and will therefore complement MyVA's broader, enterprise-wide efforts.

"MyVA" is our enterprise-wide transformation from VA's current way of doing business to one that puts the Veterans in control of how, when, and where they wish to be served. It will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. MyVA represents an opportunity to affect fundamental changes in VA's systems and structures to align with our mission and values. *The MyVA vision is to provide a seamless, unified Veteran Experience across the entire organization and throughout the country.*

Our plan has three integrated elements, or horizons. First, we plan to leverage those existing programs and initiatives that are delivering better services and benefits to Veterans. There is already a great deal of positive transformation taking place in VA and those efforts must be exploited and leveraged.

While these efforts provide a solid base to build from, the improvements are not sufficient. Thus, the second horizon of the transformation concentrates on a relatively small set of catalytic efforts focused on five initial priorities. They will accelerate the transformation now underway: expect to see significant and demonstrable progress in these targeted areas between now and the end of 2016. These initial priorities include:

- Improving the Veterans experience. At a bare minimum, every contact between Veterans and VA should be predictable, consistent, and easy. But we're aiming to make each touch point exceptional.
- Improving the employee experience. VA employees are the face of VA. They provide care, information, and access to earned benefits. They serve with distinction daily.



While improving the Veteran and employee experiences are central to our efforts, three complementary efforts will help build more robust management systems, enhance productivity, and deliver more effective results.

• Achieving support services excellence will let employees and leaders focus on assisting Veterans, rather than worrying about "back office" issues.
• Establishing a culture of continuous performance improvement will apply lean strategies to help employees examine their processes in new ways and build a culture of continuous improvement.
• Enhancing strategic partnerships will allow us to extend the reach of services available for Veterans and their families.

The third horizon is optimizing and scaling successful initiatives from the previous horizons, and growing small wins into big ones. This horizon will extend into and beyond 2017.

Since the December 18th briefing that is referenced in the question, the MyVA staff has discussed this transformational effort several times with members and congressional staff. Specific meetings include:

• 1/26/15—HVAC/SVAC/HAC/SAC Staff (teleconference)
• 1/26/15—VA 101 Brief to House Hill Staffers
• 2/6/15—SVAC MLA's
• 2/19/15—VA 101 Brief to Senate Hill Staffers
• 4/17/15—HVAC & SVAC Staff Update
• 4/28/15—Rep. Amodei (R-NV) Member-level brief
• 5/8/15—Sen. Crapo (R-ID) Staff-level brief
• 7/17/15—SVAC/HVAC Staff Update

On July 30, 2015, VA released the MyVA Integrated Plan that describes the MyVA effort in more detail. It can be accessed at: http://www.va.gov/opa/myva/docs/myva—integrated—plan.pdf

Question 2. In the fiscal year 2016 budget, VA indicates that it is leveraging eBusiness initiatives to create "efficiencies in the billing and collections process" for the Medical Care Collections Fund (MCCF). These initiatives include: "Medicare-equivalent Remittance Advices; insurance verification; inpatient/outpatient/pharmacy billing; and payments, including Electronic Funds Transfer."

a. Please describe in detail each initiative and how each has improved MCCF's billing and collections process.

b. What metrics does VA use to determine the performance of each initiative in increasing collections of MCCF?

Response. *Fiscal Year 2016 eBusiness Initiatives for the Medical Care Collections Fund (MCCF).* The MCCF Electronic Data Interchange (EDI) Development builds the transaction platform infrastructure to bill third party payers for non-service-connected care provided to veterans. The development initiatives address changes in transaction processing standards in the insurance and banking industry, those that are mandated in published regulations as well as those defined by Designated Standards Maintenance Organizations. The internal VA transaction structure must conform to current transaction standards to be able to securely communicate electronically with the commercial healthcare industry in order to collect revenue. In addition to mirroring the technology of the commercial healthcare industry, VA must also update internal functionality to reflect new and emerging needs as a result of years of iterative changes such as tracking system problems and transaction irregularities, as well as, updating reporting structures within VistA to support internal VHA organizational changes. Specifically, now that VA has moved to a consolidated revenue structure for billing and collections, the configuration of reporting within the VistA system must be modified to provide new and varied configurations for EDI system status and data analysis.

Medicare-equivalent Remittance Advices (eMRA). While the eMRA initiative is an integral part of the MCCF EDI transaction platform, there is no development needed or planned for FY 2016. VHA transmits over 4.5 million eMRA requests to Medicare which is essential for billing Medicare secondary payers. eMRA is a mature and stable part of the VistA transaction platform with no development funding needs anticipated at this time.

Insurance Verification. The electronic Insurance Verification (eIV) module in VistA provides verification of patient health insurance and Medicare eligibility, providing the essential data elements to process a claim. VHA transmitted over 9.5 million electronic eligibility transitions (HIPAA X12 270) in the last fiscal year (FY 2014). Medicare eligibility was added and increased growth 31% since FY 2010. Real-time electronic verification occurs in seconds (electronic inquiry, response, and auto-update the information in the patient insurance file). Volume metrics will continue to be collected through the testing phase in FY 2016, into FY 2017 for national deployment, and continue until the insurance identification/verification processes reach a plateau in the MCCF EDI transaction platform.

• A savings of over $6 million over the next decade will be realized by the Medicare Direct Connection (between VA and CMS), which eliminated the need to pay clearinghouses to process the Medicare eligibility inquiry for MCCF.
• Monthly cost savings are tracked and will be tracked through FY 2016 and beyond. Since the first direct transmission in August 2014, a total of 2,094,184 Medicare inquiries were processed, saving $229,588 in transaction fees.
• Future savings of over $7 million a year will be realized when the current "commercial off-the-shelf" (COTS) insurance intake and verification product is replaced with VA owned, GUI software, which is currently in development. The testing phase for this project is expected to begin in FY 2016, with savings to be realized after full deployment. Insurance card images stored on a data storage platform (SSOi) connecting all VA medical centers (VAMCs) and Community Based Outpatient Clinics (CBOCs) (approximate 6,000 users) is in current development—costs in supplies, manpower and time has not yet been realized.

Inpatient/Outpatient Medical Billing. The electronic submission of standard electronic Institutional and Professional inpatient and outpatient claims to third-party payers increases the speed of the billing and adjudication of claims, resulting in faster collections and fewer rejections. Automation of billing processes enables accurate billing to plans paying secondary to Medicare and other third party payers who are considered primary payers. The eBilling initiative is focused on industry compliance, and not efficiencies. Over 15 million electronic billing transactions occur annually (including over 4.5 million eMedicare Remittance Advice requests to Medicare). With electronic billing, communication methods are used to interact with over 1,600 payers in a standard language, making messaging about health care efficient and determination of payment fast and accurate. FY 2016 includes updates to Health Care Services Review (HCSR) transactions (ASC X12 278) based upon industry-mandated biennial review and to ensure VHA systems implement a streamlined work flow between transactions and Utilization Review (UR) staff. A performance metric for the 278 transaction will target a processing metric to third-party payers of less than 5% rejects requiring manually submitted reviews for all transactions processed. Updates to Health Care Claims Attachments transactions are planned in FY 2016, based upon industry-mandated biennial review and/or gaps identified in the implementation of attachment transactions across payers. These updates will include the ability for the end user to see the attachment that is associated with the claim and payment, thus eliminating the mailing of a paper copy of the required documentation. Claims Attachments is targeted to process to third-party payers with less than 5% of those transmitted returning with additional requests for manually submitted attachments.

Pharmacy Billing. Electronic pharmacy (ePharmacy) billing is the automated submission of real-time electronic VA Outpatient Pharmacy claims to third-party payers/Pharmacy Benefit Managers (PBM). All of the work in support of pharmacy transactions is industry standard compliance. Quarterly updates from the National Council for Prescription Drug Programs (NCPDP) are planned through FY 2016 to maintain electronic connectivity to PBMs which do not accept paper claims. An 18-second response time has been achieved for these real-time transactions. VHA submits over 11.7 million ePharmacy transactions annually from 265 VHA pharmacies. Four million prescription fills and claims are processed annually, without manual intervention. Drug profile information, contained in the adjudication received from the PBM, includes drugs prescribed and obtained outside of VA and paid for by the PBM, increasing patient safety. Days to Bill for NCPDP transactions in this fiscal year-to-date is 11.9 days, and will continue to be tracked through FY 2016 to assure there is no degradation in processing times. (Historically, the Days to Bill paper claims average was 148.7 days.)

Payments. The electronic payments (ePayments) process is comprised of the receipt of HIPAA-mandated Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) transactions. Over $1.6 billion is received annually through EFTs from over 150 third-party payers and over $2 billion in ERA transactions is posted annually through electronic accounts receivable processing. Payments processing by EFT has already been developed and deployed for VA prior to the January 1, 2014 Patient Protection and Affordable Care Act of 2010 (ACA) compliance deadline, which mandated use of the EFT across the industry. Over 70% of all payments are currently received via EFT versus a paper check. Having 70% of all revenue processed through EFT by FY 2017 is a Revenue Collections Management objective set by the Commissioner of the Department of the Treasury's Bureau of the Fiscal Service. VA's FY 2015 EFT measurement already exceeds U.S. Treasury's EFT throughput goal. This metric will continue to be monitored through FY 2016 and beyond. Auto-posting and auto-decreasing of third-party claim payments creates an efficiency with minimal manual intervention in the payment posting process, thus in-

creasing accuracy and speeding the close of health care claims receivables. Metrics will be developed to track the percentage of auto-posting and exceptions.

Question 3. VA has started to integrate mental health into primary care through its Primary Care Mental Health Integration (PCMHI) initiative. According to the budget justification, the Veterans Health Administration (VHA) has increased the penetration rate of PCMHI to 15 percent overall.

a. Please describe in detail the implementation plan, including key milestones and estimated completion dates for each milestone.

Response. VA began formal implementation of Primary Care-Mental Health Integration (PCMHI) by providing initial funding during fiscal year (FY) 2007 to 92 facilities that expressed interest. Since FY 2009, all VA medical centers and large and very large community-based outpatient clinics (CBOC) have been required, under the Uniform Mental Health Services Handbook, to have fully operational programs. Substantial growth and development of PCMHI has continued throughout, as evidenced by the following milestones and goals:

- From FY 2007 to the present, PCMHI has been supported by ongoing educational seminars and events and facility-based consultation by national subject matter experts, with the more recent addition of intensive, evidence-based facilitation through the Office of Mental Health Operations.
- In FY 2010, additional enhancement funding was provided to facilities with identified need.
- Access to mental health services occurs through various pathways including PCMHI encounters. As of the third quarter of FY 2015, 23.4 percent of all Veterans enrolled in VA primary care had mental health encounters including both specialty mental health and PCMHI use.
- As of the first quarter of FY 2015, 92.1 percent of sites required to have PCMHI embedded in Patient Aligned Care Teams (PACT) have established programs. This is an increase from 87.9 percent during the first quarter of FY 2014.
- The extent of PCMHI practice has grown steadily, from 183,048 encounters and a penetration rate (percentage of PACT patients who have a mental health encounter within the primary care clinic) of 2.2 percent during FY 2008, to 991,773 encounters and a penetration rate of 6.8 percent during FY 2014. In the first 4 months of FY 2015, 156,622 Veterans seen in primary care had at least one visit with an integrated mental health clinician, compared to 342,081 during all of FY 2014.
- The overall PCMHI penetration rate increased by 15 percent overall from FY 2013 to FY 2014 (from 5.9 percent to 6.8 percent). This reflects the percentage of the primary care population receiving mental health services as part of routine primary care. Many facilities have penetration rates in the 10–12 percent range, and as continued maturation of inter-professional care within PACT occurs we expect penetration rates to continue to increase
- An ongoing goal of the PCMHI program is to ensure that services are available on a same-day basis to a primary care appointment, when a new Veteran's needs are identified. To date, in FY 2015, 34 percent of Veterans new to PCMHI services were seen on the same day, compared to 29.9 percent at this time in FY 2014 [note: this is a cumulative rolling average].
- An additional goal is ongoing enhancement of our electronic platforms to support longitudinal follow-up and telephone care management. To that end, the Behavioral Health Laboratory (BHL) software that supports these functions has been installed at 98 VA facilities (approximately 75 percent of currently eligible sites) as of March 2015. Training and field support for its use are ongoing, and software enhancements are in development for FY 2016 to promote flexibility of use for both care management and for measurement-based mental health care more broadly.

b. Please describe the oversight conducted to ensure the mental health providers assigned to a Patient Aligned Care Team are provided office or treatment space within the primary care setting.

Response. One requirement of PCMHI programs is the co-location of mental health clinicians within the primary care setting. Given current space constraints in many facilities, not all are yet co-located. Questions related to co-location of providers are addressed in the Office of Mental Health Operations site visit process. Additionally, the PACT space design process now specifies identified space for co-located mental health providers within primary care in all new and renovated space configurations. Finally, continued development and maturation of both care management platforms and telehealth technologies will advance the extent and quality of care in a manner that is less dependent on fixed infrastructure.

Question 4. Hepatitis C is more prevalent in VA's population than in the general population. In 2013, VA estimated there were 174,000 veterans with Hepatitis C or about three percent of VA's unique patient population. In recent years, new pharma-

ceuticals have been approved that will cure Hepatitis C within a few weeks and without the devastating side effects of previous medications. According to the budget justification, VA has developed a model to determine the funding needed for these new Hepatitis C drugs.

a. Please describe in detail the model developed and the assumptions within the fiscal year 2016 and fiscal year 2017 budget requests.

Response. The Department of Veterans Affairs (VA) developed an actuarial model (Hepatitis C Model) that projects the number of enrolled Veterans infected with the Hepatitis C virus (HCV), the number of treatments for this population, and the costs associated with HCV drug treatments. This model includes data on estimated HCV prevalence rates in VA, demographics, genotype, advanced liver disease status, course of treatment, estimated number of treatments per week, treatment duration, average treatment cost per week by duration, assumed relative mortalities, probabilities for Sustained Virological Response (SVR), number of retreatments, and reinfection rates. Shifting prevalence of HCV in the VA population was also modeled in a manner consistent with enrollment projections from the VA Enrollee Health Care Projection Model (EHCPM). Recent trends were used to project behaviors regarding HCV infection rates and screening increases.

To estimate the additional drug acquisition costs associated with providing HCV drug treatments from FY 2014 to FY 2017, the average cost per treatment was applied to the total number of treatments expected to be performed each fiscal year. The assumed cost for each course of treatment was provided by VA's Pharmacy Benefit Manager (PBM) in July 2014. The costs per treatment were assumed to stay constant over time. New treatments that became available starting in FY 2015 were assumed to be cost-neutral with regards to known treatments at the time the cost assumptions were developed.

The projection model includes prescription drugs that are currently available.

- The primary treatment regimens that are currently being prescribed include:
  sofosbuvir/ledipasvir ± ribavirin 12-week;
  ombitasvir/paritaprevir/ritonavir/dasabuvir ± ribavirin 12-week;
  sofosbuvir/ledipasvir 8-week;
  sofosbuvir/ledipasvir 24-week; and sofosbuvir/ribavirin 24-week.
- The treatment regimens that became available in October 2014 include:
  sofosbuvir/ledipasvir 8-week;
  sofosbuvir/ledipasvir 12-week; and
  sofosbuvir/ledipasvir 24-week.
- The treatment regimens that became available in December 2014 include:
  ombitasvir/paritaprevir/ritonavir/dasabuvir ± ribavirin 12-week and 24-week.
- Future regimens include Daclatasvir and Sofosbuvir 12-week and 24-week.

The initial treatment projections from FY 2015 through 2023 were developed to target approximately 13,000 treatment evaluations annually, based on treatment starts in FY 2014. The estimated capacity within VA to treat HCV patients at the time of approval of new treatment regimens by the Food and Drug Administration was based on the number of treatment starts in FY 2014, which was low due to long and arduous treatment regimens available at the time. This estimated capacity was considered as a constraint on the model when projecting the 13,000 treatment evaluations. The variation in projected treatments and costs between different Veteran Integrated Service Networks (VISN) was related to the underlying patient demographics within each VISN, differences in HCV provider treatment capacity, improved infrastructure leading to differences in the numbers of Veterans started on treatment, and differing approaches within VISNs to prioritization of patients at different disease. Of note, a VA-wide prioritization plan based on disease stage was implemented in May 2015 after FY 2015 funds to treat HCV were exhausted in nearly all facilities.

Hepatitis C Model Projection Methodology and Assumptions

The Hepatitis C Model projects the HCV infection status of enrollees year-over-year in a manner consistent with clinical assumptions and enrollment estimates in each year. The model projects the following Hepatitis C statuses for enrollees in each projection year:

- Uninfected—Veteran enrollees who have not contracted HCV
- Undiagnosed Infected—Enrolled veterans with HCV who have not yet been diagnosed as HCV positive
- Diagnosed Infected—Enrollees infected with HCV who have been diagnosed and are candidates for treatment

• Infected Non-Candidates—Enrollees infected and diagnosed with HCV but, through VHA evaluation, have been deemed not suitable for treatment or have declined treatment
• SVR—Enrollees who have effectively been "cured" through treatment

In each year of the projections, treatments occur only within the Diagnosed Infected population and are isolated to those enrollees who are considered treatment candidates. It is assumed that approximately 30% of all enrollees are not considered candidates for treatment for a variety of reasons, including clinical reasons and by individual choice. If a patient receives treatment in a given year and fails to attain SVR, the patient remains eligible for treatment in a future year. However, if after two years of attempted treatment the patient still fails to attain SVR, the patient is no longer a candidate for treatment in the third year. It is possible that an HCV patient may transition into the Diagnosed Infected population and receive treatment in the same year.

In order to determine when a transition for treatment occurs, along with other assumptions, a stochastic model is used to assign patient statuses based on a probability distribution. Transitions and treatments for each individual are determined by choosing a random "seed" number that dictates which of the available outcomes is assumed to occur. Although this methodology is built upon a random process, the large size of the modeled population ensures that the proportion of individuals transitioning to each particular status will approximately equal the assumed probability of that event occurring. The model is also run 30 times and average results are used in order to reduce the variability in results due to random fluctuation.

b. What are the long-term savings to VA in curing Hepatitis C?

Response. The Veterans Health Administration (VHA) is assessing the short- and long-term impact on overall health costs associated with treatment of Veterans' Hepatitis C. To assess these costs, VHA evaluated 14,206 Veterans who received therapy beginning in FY 2005 with at least 5 years of time after finishing treatment. At 5 years post-treatment, patients with SVR (vs. no SVR) had an average adjusted mean cost savings of $5,200 per patient overall, $15,705 in cirrhotics, and $3,501 in non-cirrhotics. The unadjusted mean cost savings was $17,962 per patient overall, $22,857 in cirrhotics, and $14,204 in non-cirrhotics using a 5-year follow up period, means VHA is not currently able to assess the impact of newer Hepatitis C medications on long-term savings. In the general population, the best available study shows an adjusted cost savings of $2,648 per year in a similar large sample of managed care patients with SVR vs. no SVR (Manos MM et al. Journal of Managed Care Pharmacy, July/Aug 2013).

Question 5. In part, the President's Executive Order (E.O.) 13625, "Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families," directed VA to work closely with the Department of Defense (DOD) and the Department of Health and Human Services (HHS) to improve research on suicide prevention. To carry out this E.O., VA, DOD, and HHS have partnered to implement the Cross Agency Priority Goal (CAP Goal) and the 19 new Executive Actions announced in August 2014 to "improv[e] access and reduc[e] barriers to mental health care." Please describe in detail how VA intends to implement the CAP Goal and the 19 new Executive Actions.

Response. The Departments of Veterans Affairs (VA), Defense (DOD) and Health and Human Services (HHS) have been working closely together to enhance mental health services to Veterans, servicemembers and military families. Accomplishments resulting from the President's 2012 Executive Order (#13625) are highlighted below:

• Implemented a joint DOD/VA national suicide prevention campaign and increased Veterans Crisis Line staffing by 50 percent.
• Established the National Research Action Plan and invested $107 million into two joint research consortia on Post Traumatic Stress Disorder (PTSD) and the Chronic Effects of Neurotrauma.
• Completed VA pilot partnerships with 24 community-based mental health and substance abuse disorder treatment providers.
• Expanded outreach campaigns to raise awareness and reduce the stigma associated with seeking mental healthcare.
• Launched training in military culture competence for VA, DOD, and community healthcare professionals.
• Established the Interagency Task Force to coordinate and oversee interagency mental health activities, resulting in annual interagency recommendations for improvement.
• Added 1,669 mental health clinical providers and 973 peer support staff in VA.
• Established policies and implemented a process for connecting Veterans in crisis to a mental health worker within 24 hours.

Interagency work in this area has continued under the auspices of the Cross Agency Priority Goal (CAP Goal) on servicemember and Veteran mental health, which was announced in March 2014. Immediately following the announcement of the CAP Goal, each of the three departments identified action officers and subject matter experts to develop 3-year work plans consisting of actionable milestones and performance indicators (metrics). Action officers for each department meet weekly to discuss progress on the milestones and indicators. Progress is tracked and reported quarterly on the public facing Web site www.performance.gov. Detailed updates on the CAP Goal activities are provided on a quarterly basis to executive branch leadership and posted publicly on performance.gov. Notable highlights from the progress of the CAP Goal efforts include the following:

• Visits to the Make the Connection outreach campaign Web site continue to trend upward (722,698 so far in FY 2015) and are on track to substantially exceed the targeted 10% increase for this year.Established an interagency workgroup to identify, expand, and promote DOD, VA, and HHS efforts to reduce negative perceptions associated with seeking mental health care and increase awareness of resources.

• "These Hands" public service announcements (PSA) for the Veterans Crisis Line/Military Crisis Line are in the top 5 percent of PSAs being aired nationally.

• Views of the VA Community Provider Toolkit (www.mentalhealth.va.gov/communityproviders/) also continue to increase and content continues to be enhanced to meet the needs of clinicians who are serving Veterans in the community.

Further building upon the activities of the EO #13625 and the CAP-Goal, VA, DOD, and other Federal agencies have taken a number of steps in response to the President's August 2014 Executive Actions (EA). Similar to the CAP-Goal, the Departments have identified Action Officers and subject matter experts for each of the 19 items and collaborative work is underway. Highlights of interagency EA progress to date include the following:

• DOD's inTransition contract is in the process of being modified to establish an automatic enrollment for Servicemembers preparing for transition to Veteran status.

• Military Culture Competence training is being disseminated to community providers in coordination with the White House Joining Forces initiative.

• VA and IRS are providing Operation Save suicide prevention training to volunteer tax preparers who are working with Veterans.

• DOD, VA, and HHS are working together to address risk of opioid overdose risk by increasing the availability of naloxone, a medication that reverses the effects of opiates. VA policy was revised in February 2015 to ensure that Servicemembers transitioning to VA care will maintain access to medication prescribed by DOD providers.

Question 6. VHA has pointed to its use of and training in evidence based psychotherapies (EBPs) and, according to the budget justification, has provided training to more than 7,500 providers. The justification also states: "VHA will expand its efforts to * * * evaluate the impact of training in and delivery of these therapies." Please describe in detail the metric used to evaluate the training and delivery of EBPs.

Response. VHA's competency-based EBP training model includes two key components designed to create mastery and promote successful EBP implementation: (a) participation in an in-person, experientially-based workshop, and (b) ongoing telephone-based clinical consultation on actual therapy cases with a training program consultant who is an expert in the particular EBP. Ongoing formative and summative program evaluation is a central component of the VA EBP training programs and focuses on both staff and Veteran outcomes. Additionally, alternative training methods are being piloted and will be evaluated against the current training standards.

Therapist Outcomes—For evaluating EBP therapists-in-training, the EBP training programs use survey measures to collect data at several points in time: before and after training; and during, immediately after, and six months after the consultation phase. Variables assessed include: therapists'-in-training ratings of (1) the trainers; (2) training program quality; (3) self-rated knowledge and skills acquisition; (4) intent to apply skills to their practice; (5) self-efficacy in applying EBP skills; (6) attitudes regarding use of the EBP; and more. In addition, expert EBP consultants assess the outcomes of therapists-in-training by using an EBP-specific competency rating scale to rate actual sessions. These ratings provide reliable and detailed feedback on their EBP skills.

VHA program evaluation has shown that this intensive consultation, combined with ratings of actual clinical cases, is crucial to improving provider competencies.

Consultation improves therapists' sense of efficacy in delivering EBPs that are not evident when therapists only attend a workshop.

Veteran Outcomes—The EBP training programs also assess Veterans' responses to EBPs. To date, the VHA EBP program evaluation data indicate that Veterans' improvements in target symptoms have been in the medium-to-large or large range for Post Traumatic Stress Disorder, insomnia, depression, and chronic pain. These results are quite promising considering they come from Veterans, often with complex or chronic problems, who are being treated by EBP therapists-in-training. Program evaluation for some of the newer EBP training programs, which focus on treating substance abuse and building motivation to change problematic behaviors, are fully underway, but results are not yet published.

Beyond symptom relief, Veterans have also shown significant improvement in their quality of life (both psychologically and physically) and in their therapeutic alliance scores, indicating that Veterans agree with their therapists on the goals and tasks of therapy and feel a bond with their therapists. VHA data indicate completion rates of around 70 percent across treatments, relative to the mean completion rate of 54 percent reported in studies of psychotherapy with the general population. These findings indicate a high degree of Veteran acceptance of these therapies, which may be in part due to the strong emphasis the training programs place on building strong working alliances between the trainers and their Veteran patients.

Increasingly, researchers are focusing on the effects of EBPs on reducing medical utilization and health care costs. For example, completion of EBPs for Post Traumatic Stress Disorder has demonstrated a 30 percent reduction in mental health service utilization and about a 40 percent reduction in health care costs in the year following treatment. Studies from the National Health Service in the United Kingdom have demonstrated that EBP treatment for a wide variety of mental health conditions results in net savings to the system above and beyond the costs of training.

Delivery of EBPs—Previously, there was no mechanism for tracking the delivery of EBPs using administrative data. In the first two quarters of fiscal year 2015, VHA released nine sets of documentation templates for the EBPs that treat Post Traumatic Stress Disorder, depression, serious mental illness, insomnia, and relationship distress. Six more sets are planned for release at the beginning of next fiscal year. These documentation templates are for the EBPs that treat chronic pain or substance use, increase motivation to change, and track the offering of EBPs to Veterans. For the first time, VHA can directly measure the delivery of the EBPs that have documentation templates.

A beta version of a national dashboard was just released that documents the number of unique Veterans who have had two or more sessions of an EBP since the templates were deployed. Currently, the EBP utilization data, available at the national, VISN, and facility levels, can be viewed by any VA staff member. EBP data is displayed in near real time. New parameters and reporting capabilities will continue to be added as data definitions are developed and refined. The release of the EBP documentation templates and the deployment of the national EBP dashboard will greatly increase VHA's ability to focus implementation efforts at sites with low EBP delivery and to learn the best practices from high achieving sites.

Improving Access to EBP Training—The EBP training programs are piloting alternative training methods that rely less on national in-person workshops. During the piloting phase, the training programs will be evaluating whether the alternative training methods are as effective in terms of therapist and Veteran outcomes as the in-person workshops that have demonstrated efficacy.

Recent restrictions on employee travel and conferences have impacted VHA's ability to train providers. In order to adequately train the VHA mental health workforce, as well as improve the implementation and sustainability of EBPs, alternative training methods must be developed. Since 2007, VHA has trained over 9,000 unique VA staff in one or more EBP. Nevertheless, there is ongoing demand for EBP training due to new staff joining VA, staff turnover, and changes in job assignments.

In order to better meet this demand, two models are being piloted and evaluated. One is a regional training model whereby the national EBP training program train staff adept in an EBP to become trainer/consultants. These trainer/consultants then conduct local or regional trainings and provided the follow-up consultation within their VISNs. This model is responsive to local needs and schedules but has the disadvantages of trainers/consultants having to get local permission to block their clinical schedules to provide training and consultation; and local facilities having to fund travel within their regions. In the current national model, the EBP training programs reimburse VA sites for the percentage of time staff devote to national training efforts and pay for training participant travel.

The other training model being piloted uses a blended learning strategy whereby the didactic portions of the workshop are presented in web courses, the experiential role-play training is conducted over video conferencing technology in small cohorts led by an EBP expert, and consultation is provided as it is currently (by nationally-funded consultants who provide expert ratings of actual clinical cases and give feedback to training participants on small group conference calls).

In short, VA uses a wide variety of metrics to track the number of therapists trained in EBPs, the therapist and Veteran outcomes with EBP training cases, the efficacy of EBP training methods, and, now, the numbers of Veterans engaged in various EBP treatments. In the near future, VA plans to assess the offering of EBPs, completion rates, and, eventually, clinical outcomes for Veterans in EBP.

Question 7. The revised estimate for the fiscal year 2016 advance appropriations request for the Medical Support and Compliance appropriations account indicates a $114.6 million decrease for VISN headquarters and a $37.3 million increase for VHA Central Office (VHACO).

a. What accounts for the change in funding for the VISN headquarters and VHACO?

Response. The 2016 Revised Request adjusts the estimate for the latest actual obligations (2014), as opposed to the 2016 Advance Appropriation estimate (based on the 2013 actual obligations). The 2016 Revised Request for the VISN Headquarters reflects the funding necessary to maintain the 2014 current service levels, allowing for inflation; the proposed pay raise from 1 percent to 1.3 percent; and changes in full-time equivalent employees (FTE). The 2016 Revised Request for the VHACO reflects the funding necessary to maintain the 2014 current service levels, allowing for inflation; the proposed pay raise from 1 percent to 1.3 percent; and FTE held steady at the 2014 level.

b. If the changes are due to the overall increase or decrease in FTE, please describe in detail the justification for the increase or decrease and whether the increase or decrease is a shift of FTE between VISN headquarters and VHACO.

Response. Sixty-eight percent of the funding for Medical Support and Compliance will go toward VAMCs, Other Field Activities, and VISN Headquarters. The majority of the funding increase is due to additional staffing requirements for field activities at the VA medical centers and VISNs. The additional positions are being added to the Medical Centers and VISNs to support and fulfill the Secretary's vision of becoming a more Veteran-centric organization, and to be able to provide top-level customer service in a more efficient manner to our Veterans; as a result, some of the positions we are increasing are: Police, Personnel Management Specialist, Contract Administrator, Voucher Examiner, Claims Assistant, Emergency Management Series, Medical Records Clerk/Technician, Health Systems Specialist, Administrative Officer, Security Clerical & Assistance. These personnel are in direct support of VA's objective to manage and improve VA operations to deliver seamless and integrated support. These personnel will support healthcare workers in order to deliver the healthcare services that our Veterans expect. FTE estimates for VHA Central Office and VHA National Consolidated Activities remain steady at their 2014 levels.

Question 8. VA's goal is to end veteran homelessness this year. If that goal is not met, what is the plan for funding homelessness programs for fiscal years 2016 and 2017? If that goal is met, will funding need to be shifted to sustain preventative services? If so, how?

Response. The goal of ending Veteran homelessness will be measured according to the January 2016 Point in Time count, the results of which are expected by summer 2016. Given the timing of this information, we do not anticipate deviating from the current requested budgets for fiscal years 2016 and 2017. Available funding has been prioritized among our programs to achieve three objectives:

- Maintain current case management services and provide interventions as needed to those high-risk/high-need Veterans we have been able to house, so that they do not return to homelessness;
- Ensure resources are available to identify Veterans at-risk for homelessness, and prevent these Veterans from falling into homelessness; and
- Provide immediate access to housing to Veterans who fall into homelessness so that they are moved as rapidly as possible to safe and stable settings, putting them on a path to permanent housing.

Medical Facilities

Question 9. The fiscal year 2016 advance appropriations for medical facilities have been revised significantly in this year's budget request. Numerous subaccounts, such as plant operations, leases, and operating equipment maintenance, and repair, each have a revised estimate of more than $200 million below the advance appropria-

tions. Conversely, recurring maintenance and repair and non-recurring maintenance each have a revised estimate of more than $200 million above the amount provided in advance appropriations.

a. Why were the fiscal year 2016 advance appropriations inaccurate?

Response. The 2016 advance appropriations estimates for plant operations, leases, operating equipment maintenance and repair, and recurring maintenance and repair reflect the most recent available obligation data (2013 actuals). The estimates have been updated to reflect the latest actual obligations (2014) and an inflationary increase over the 2015 Current Estimate. Non-recurring maintenance estimates were revised to address high priority emerging capital needs, as identified through the Strategic Capital Investment Planning (SCIP) process.

b. Please detail the process used to identify the advance appropriated funds necessary for medical facilities.

Response. The 2016 advance appropriation took into account the latest actual obligations (2013); estimates for Obligations by Functional Area (Engineering and Environmental Management Services, Plant Operations, etc.) and Obligations by Object Class (utilities, rent, etc.); capital needs as identified through the SCIP process (NRM); a one percent pay raise; and adjustments to funding availability (transfers to Joint DOD/VA Medical Facility Demonstration Fund and reimbursements).

Question 10. The Non-Recurring Maintenance (NRM) subaccount is $708 million for fiscal year 2016, an increase of $247.4 million over the amount provided in advance appropriations. The budget request indicates that this is offset by a decrease of $311.4 million for leases based on revised estimates.

a. What accounts for the $247.4 million increase in NRM?

Response. VA's NRM project list is greater than $9 billion. The requested increase in NRM in FY 2016 above the Advance Appropriation amount is an attempt to address more of these NRM projects within the total requested resources in the President's Budget.

b. What accounts for the $311.4 million decrease in leases?

Response. The Veterans Choice Act Section 801 provided funding for leases. VA projects that $313 million of Section 801 funding will be used to support new leases in 2015 and 2016 and this amount was reduced from our request. Also prior to this year's budget submission, VA estimated medical facility lease costs based on historical trends in the object classes in which lease obligations are recorded. Beginning with this budget, VA has moved to a specific requirement by lease rather than relying on overall trends.

Question 11. The NRM subaccount is projected to increase by $71.8 million or 11.2 percent between fiscal year 2015 and fiscal year 2016 and decrease by $247.4 million or 35 percent between fiscal year 2016 and fiscal year 2017.

a. The advance appropriation each year for the NRM subaccount is $460.6 million and each year the revised estimate is significantly higher. What metrics does VA use to determine the NRM funding request?

Response. VA's total capital investments are balanced across NRM, Major Construction and Minor Construction by the Strategic Capital Investment Plan (SCIP) process, and are balanced within the total requested resources in the President's Budget Advance Appropriation request.

b. Why does the 2017 advance appropriations request only include Object Class 32 while the actual expenditures include Object Classes 10, 21–26, 31, 32, 41, and 43?

Response. Reported actual obligations for 2014 include errors in the VA Financial Management System that were made too late in the year to identify and correct before the required fiscal year close out activities made those errors a part of the official financial record. VA's budget request does not assume that those errors will be repeated in future years.

Question 12. According to the fiscal year 2016 budget, VA will spend $598 million to activate medical facilities in fiscal year 2016. And, the estimate for activations for fiscal year 2016 increased by $468 million over the amount provided in advance appropriations.

a. Please break out the $598 million by appropriations account.

VA Response:

Medical Services: $443 million
Medical Support & Compliance: $54 million
Medical Facilities: $101 million

b. Please provide a full list of the facilities that will be activated with these funds, with the amount of funding estimated for each facility broken down into non-recurring and recurring costs.

Activation Projects FY 2015-FY 2017 #22
Project Detail

					Non-Recurring Estimates - Annual Allocations	Recurring Estimates - Annual Allocations	Combined Rough ACBM Estimates - Annual Allocations
VISN	Project	State	Project Name	Project Category[1]	FY 2016 Non Recurring Estimate	FY 2016 Recurring Estimate	FY 2016 Combined Estimate
1	Lease	MA	Boston - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
1	Lease	VT	Colchester, VT - Community Based Outpatient Clinic	CBOC - Expansion	$0	$0	$0
1	Lease	CT	West Haven - Outpatient Clinic Lease	CBOC - New	$0	$0	$0
1	Lease	MA	Worcester - Outpatient Clinic Lease	CBOC - Expansion	$0	$0	$0
2	Lease	NY	Buffalo, NY - Day Treatment Center	CBOC - Expansion	$0	$0	$0
2	Lease	NY	Rochester - Outpatient ClinicLease	HCC	$0	$0	$0
3	Lease	NY	Brick - Outpatient Clinic Lease	CBOC - Expansion	$0	$0	$0
4	Lease	PA	Butler - Health Care CenterLease	HCC	$716,750	$0	$716,750
5	Lease	MD	Charlotte Hall, MD - Community Based Outpatient Clinic	CBOC - New	$0	$0	$0
6	Lease	NC	Charlotte - Health Care CenterLease	HCC	$31,980,825	$0	$31,980,825
6	Lease	NC	Fayetteville - Health Care CenterLease	HCC	$219,124	$2,618,230	$2,837,355
6	Lease	NC	Greenville NC - Outpatient ClinicLease	CBOC - Expansion	$0	$40,863,436	$40,863,436
6	Lease	NC	Wilmington - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
6	Lease	NC	Winston-Salem - Health Care CenterLease	HCC	$52,697,577	$0	$52,697,577
7	Lease	SC	Anderson - Outpatient ClinicLease	CBOC - Expansion	$573,209	$0	$573,209
7	Lease	GA	Atlanta - Specialty CareLease	CBOC - Expansion	$1,435,380	$8,763,569	$10,198,949
7	Lease	AL	Birmingham - Clinical Annex/Outpatient ClinicLease	CBOC - New	$1,149,621	$0	$1,149,621
7	Lease	SC	Charleston - Outpatient Clinic Lease	CBOC - New	$0	$0	$0
7	Lease	GA	Cobb County - Outpatient Clinic Lease	CBOC - New	$0	$0	$0
7	Lease	GA	Columbus - Community-Based Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
7	Lease	SC	Greenville SC - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
7	Lease	GA	Hinesville - Community-Based Outpatient ClinicLease	CBOC - Expansion	$0	$678,692	$678,692
7	Lease	AL	Huntsville - Outpatient ClinicLease	CBOC - Expansion	$1,306,050	$0	$1,306,050
7	Lease	AL	Montgomery - Health Care CenterLease	HCC	$3,951,711	$0	$3,951,711
7	Lease	SC	Myrtle Beach - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
7	Lease	GA	Savannah - Community-Based Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
8	Lease	FL	Brandon - Outpatient Clinic (Tampa)Lease	CBOC - New	$0	$0	$0

Response. See attached.

Activation Projects FY 2015-FY 2017 #22

Project Detail

					Non-Recurring Estimates - Annual Allocations	Recurring Estimates - Annual Allocations	Combined Rough ACBM Estimates - Annual Allocations
VISN	Project	State	Project Name	Project Category[1]	FY 2016 Non Recurring Estimate	FY 2016 Recurring Estimate	FY 2016 Combined Estimate
8	Lease	FL	Jacksonville - Satellite Outpatient ClinicLease	CBOC - New	$0	$0	$0
8	Lease	PR	Mayaguez - Satellite Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
8	Lease	FL	New Port Richey - Health Care Center Lease	HCC	$0	$0	$0
8	Lease	PR	Ponce - Health Care Center Lease	HCC	$0	$0	$0
8	Lease	PR	San Juan - Mental Health Residential & Pyschosocial Outpatient ClinicLease	CBOC - New	$0	$0	$0
8	Lease	FL	St. Augustine, FL - Community Based Outpatient Clinic	CBOC - Expansion	$0	$0	$0
8	Lease	FL	Tallahassee - Outpatient ClinicLease	CBOC - Expansion	$13,534,255	$692,555	$14,226,810
8	Lease	FL	Tampa - Primary Care AnnexLease	HCC	$0	$4,435,645	$4,435,645
8	Lease	FL	Tampa, FL - Mental Health Clinic	CBOC - Expansion	$0	$0	$0
9	Lease	TN	Chattanooga - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
10	Lease	OH	Mansfield - Satellite Outpatient ClinicLease	CBOC - New	$0	$9,573,126	$9,573,126
11	Lease	IN	Fort Wayne - Community Based Outpatient ClinicLease	CBOC - New	$0	$1,584,303	$1,584,303
11	Lease	MI	Grand Rapids - Community Based Outpatient ClinicLease	CBOC - Expansion	$1,727,400	$4,599,304	$6,326,705
11	Lease	IN	South Bend - Community Based Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
11	Lease	OH	Toledo - Community Based Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
12	Lease	WI	Green Bay - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
12	Lease	IL	Hines - Research Lease	Other Lease	$0	$0	$0
15	Lease	MO	Cape Girardeau - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
15	Lease	KS	Johnson County - Outpatient ClinicLease	CBOC - New	$0	$0	$0
16	Lease	TX	Houston - Research Lease	Other Lease	$0	$0	$0
16	Lease	LA	Lafayette - Outpatient Clinic Lease	CBOC - New	$0	$0	$0
16	Lease	LA	Lake Charles - Outpatient Clinic Lease	CBOC - New	$0	$0	$0
16	Lease	AL	Mobile - Outpatient ClincLease	CBOC - Expansion	$0	$0	$0
16	Lease	MO	Springfield - Community-Based Outpatient ClinicLease	CBOC - New	$0	$0	$0

Activation Projects FY 2015-FY 2017 #22

Project Detail

					Non-Recurring Estimates - Annual Allocations	Recurring Estimates - Annual Allocations	Combined Rough ACBM Estimates - Annual Allocations
VISN	Project	State	Project Name	Project Category[1]	FY 2016 Non-Recurring Estimate	FY 2016 Recurring Estimate	FY 2016 Combined Estimate
16	Lease	TX	Tomball, TX - Community Based Outpatient Clinic	CBOC - New	$0	$0	$0
16	Lease	OK	Tulsa - Outpatient ClinicLease	HCC	$0	$0	$0
17	Lease	TX	Austin - Outpatient ClinicLease	HCC	$0	$0	$0
17	Lease	TX	Corpus Christi - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
17	Lease	TX	McAllen - Outpatient ClinicLease	CBOC - New	$0	$669,789	$669,789
17	Lease	TX	San Antonio - Health Care Center Lease	HCC	$0	$0	$0
17	Lease	TX	Tyler, TX - Outpatient Clinic	CBOC - Expansion	$0	$0	$0
18	Lease	NM	Albuquerque - Outpatient Clinic Lease	CBOC - Expansion	$0	$0	$0
18	Lease	AZ	Gilbert, AZ - Community Based Outpatient Clinic	CBOC - Expansion	$0	$8,372,657	$8,372,657
18	Lease	TX	Lubbock - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
18	Lease	AZ	Phoenix - Outpatient ClinicLease	HCC	$0	$0	$0
19	Lease	MT	Billings - Satellite Outpatient ClinicLease	CBOC - Expansion	$0	$7,025,225	$7,025,225
19	Lease	CO	Colorado Springs - Community-Based Outpatient Clinic RelocationLease	CBOC - Expansion	$0	$3,815,781	$3,815,781
19	Lease	CO	Denver, CO - Residential Treatment Facility	CBOC - New	$0	$4,858,230	$4,858,230
19	Lease	CO	Lakewood, CO - Community Based Outpatient Clinic	CBOC - New	$0	$3,434,199	$3,434,199
19	Lease	CO	Pueblo, CO - Community Based Outpatient Clinic	CBOC - Expansion	$0	$0	$0
20	Lease	OR	East Portland, OR - Community Based Outpatient Clinic	CBOC - Expansion	$0	$0	$0
20	Lease	OR	Eugene - Community-Based Outpatient ClinicLease	CBOC - Expansion	$1,683,249	$6,177,438	$7,860,687
20	Lease	OR	Salem - Community-Based Outpatient ClinicLease	CBOC - Expansion	$0	$7,742,071	$7,742,071
21	Lease	CA	Chico - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
21	Lease	HI	Honolulu - Health Care Center Lease	HCC	$0	$0	$0
21	Lease	CA	Mare Island, CA - VISN/Regional Directors Offices	CBOC - New	$0	$0	$0
21	Lease	CA	Monterey - Health Care CenterLease	HCC	$6,932,229	$0	$6,932,229
21	Lease	CA	Redding - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
21	Lease	CA	San Francisco - Research LeaseLease	CBOC - New	$0	$0	$0

Activation Projects FY 2015-FY 2017 #22

Project Detail

					Non-Recurring Estimates - Annual Allocations	Recurring Estimates - Annual Allocations	Combined Rough ACBM Estimates - Annual Allocations
VISN	Project	State	Project Name	Project Category[1]	FY 2016 Non Recurring Estimate	FY 2016 Recurring Estimate	FY 2016 Combined Estimate
21	Lease	CA	San Jose - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
21	Lease	CA	Vallejo, CA - Co-Location of CFM's Western Regional Office and VISN 21 Offices	CBOC - New	$3,162,282	$0	$3,162,282
22	Lease	CA	Bakersfield - Community-Based Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
22	Lease	CA	Chula Vista - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
22	Lease	CA	Loma Linda - Health Care CenterLease	HCC	$9,119,657	$0	$9,119,657
22	Lease	CA	San Diego - Outpatient ClinicLease	CBOC - Expansion	$0	$0	$0
23	Lease	IA	Knoxville, IA - Community Based Outpatient Clinic	CBOC - New	$0	$0	$0
23	Lease	NE	Lincoln - Outpatient ClinicLease	CBOC - New	$0	$0	$0
1	523-119	MA	Brockton - Spinal Cord Injury (SCI) (Overview - OV)	Special Emphasis Program	$0	$0	$0
2	528-400	NY	Canandaigua - New Construction and Renovation	Replacement Hospital - Consolidation	$0	$0	$0
2	528-708	NY	Syracuse - Addition For SCI Center (OV)	Special Emphasis Program	$0	$429,663	$429,663
3	526-315	NY	Bronx - Spinal Cord Injury Center (SCI) (OV)	Special Emphasis Program	$0	$0	$0
3	630-600	NY	Manhattan, NY - Hospital Restoration and Renovation	Renovation	$20,096,929	$0	$20,096,929
4	646-500	PA	Pittsburgh - Medical Center Consolidation (OV)	Replacement Hospital - Consolidation	$0	$0	$0
5	512-173	MD	Perry Point - Replacement CLC	Renovation	$0	$0	$0
7	508-057	GA	Atlanta - Modernize Patient Wards (OV)	Renovation	$0	$0	$0
8	516-005	FL	Bay Pines - Inpatient/Outpatient Improvements	Renovation	$1,907,509	$183,538	$2,091,047
8	516-400	FL	Lee County - Outpatient Clinic (Bay Pines)	HCC	$0	$0	$0
8	673-950	FL	Orlando - New Medical Facility (OV)	Replacement Hospital - Expansion	$7,400,637	$71,564,209	$78,964,846
8	672-085	PR	San Juan - Seismic Corrections Bldg. 1 (OV)	Renovation	$289,753	$0	$289,753

Activation Projects FY 2015-FY 2017 #22

Project Detail

					Non-Recurring Estimates - Annual Allocations	Recurring Estimates - Annual Allocations	Combined Rough ACBM Estimates - Annual Allocations
VISN	Project	State	Project Name	Project Category [1]	FY 2016 Non-Recurring Estimate	FY 2016 Recurring Estimate	FY 2016 Combined Estimate
8	673-900	FL	Tampa - Polytrauma and Bed Tower (OV)	Special Emphasis Program	$0	$0	$0
9	603-320	KY	Louisville - Replacement Med Center / Regional Office	Replacement Hospital - Expansion	$0	$0	$0
15	589-006	MO	Columbia - Operating Suite Replacement	Major Addition	$0	$1,163,278	$1,163,278
15	657-313	MO	St. Louis (JB) - Med Facility Improv & Cem Expansion (OV)	Renovation	$1,234,446	$0	$1,234,446
15	657-309	MO	St. Louis (JC) - Replace Bed Tower & Clinic Expansion (OV)	Major Addition	$0	$0	$0
16	520-317	MS	Biloxi - Restoration Of Hospital/Consolidation (OV)	Renovation	$1,975,280	$0	$1,975,280
16	564-302	AR	Fayetteville - Clinical Addition	Major Addition	$0	$3,567,563	$3,567,563
16	629-401	LA	New Orleans - Restoration/Replacement Medical Facility (OV)	Replacement Hospital - Expansion	$56,459,127	$51,187,782	$107,646,908
17	549-615	TX	Dallas - Clinical Expansion for Mental Health	Major Addition	$0	$0	$0
17	549-820	TX	Dallas - Spinal Cord Injury (SCI)	Special Emphasis Program	$0	$0	$0
17	671-048	TX	San Antonio - Polytrauma Center, & Renovation of Exist Bldg. 1	Special Emphasis Program	$582,190	$0	$582,190
17	674-117	TX	Temple - IT Building	Major Addition	$0	$0	$0
19	554-501	CO	Denver - Replacement Medical Center Facility (OV)	Replacement Hospital - Expansion	$2,552,523	$20,364,964	$22,917,487
20	663-403	WA	American Lake - Seismic Corrections of Bldg. 81	Renovation	$0	$0	$0
20	648-077	OR	Portland, OR - Portland VAMC - Seismic Retrofit and Renovation - Buildings 100 and 101	Renovation	$0	$0	$0
20	663-405	WA	Seattle - B101 Mental Health (OV)	Major Addition	$17,246,726	$0	$17,246,726
20	663-406	WA	Seattle - Correct Seismic Deficiencies B100, NT & NHCU	Renovation	$19,470,433	$13,075,925	$32,546,358
20	687-400	WA	Walla Walla - Multi Specialty Care (Overview)	Major Addition	$0	$0	$0
21	612-115	CA	Alameda - Outpatient Clinic and Columbarium	CBOC - Expansion	$0	$0	$0

Activation Projects FY 2015-FY 2017 #22

Project Detail

					Non-Recurring Estimates - Annual Allocations	Recurring Estimates - Annual Allocations	Combined Rough ACBM Estimates - Annual Allocations
VISN	Project	State	Project Name	Project Category[1]	FY 2016 Non Recurring Estimate	FY 2016 Recurring Estimate	FY 2016 Combined Estimate
21	640-423	CA	Livermore - Livermore Realignment (Palo Alto) (OV)	Replacement Hospital - Consolidation	$0	$0	$0
21	640-424	CA	Palo Alto - Centers for Ambulatory Care and Polytrauma Rehabilitation (OV)	Major Addition	$3,781,369	$111,310	$3,892,679
21	640-413	CA	Palo Alto - Seismic Corrections, Bldg. 2	Major Addition	$0	$0	$0
21	654-083	NV	Reno - Upgrade B1 Seismic, Life Safety, Utility Corrections & Expand Clinical Services	Renovation	$0	$0	$0
21	662-402	CA	San Francisco - Correct Seismic Deficiencies in Buildings 1,6,8 & 12	Renovation	$0	$0	$0
22	593-202	NV	Las Vegas - New Medical Facility (OV)	Replacement Hospital - Expansion	$0	$57,434,863	$57,434,863
22	600-405	CA	Long Beach - Seismic Corrections - Mental Health & Community Living Center	Renovation	$0	$0	$0
22	600-402	CA	Long Beach - Seismic Corrections/Clinical,B-7 & 126	Renovation	$0	$0	$0
22	691-408	CA	Los Angeles - Construct New Essential Care Tower/B500 Seismic Corrections and Renovations	Replacement Hospital - Consolidation	$0	$0	$0
22	691-406	CA	Los Angeles - Seismic Corrections - 12 Bldgs.	Renovation	$0	$0	$0
22	664-401	CA	San Diego - SCI, Seismic Corrections - (Overview)	Special Emphasis Program	$0	$0	$0
23	636-406	NE	Omaha - Omaha- Replacement Facility	Replacement Hospital - Expansion	$0	$0	$0
				Totals:	$263,186,238	$334,987,346	$598,173,584

c. Please provide a detailed explanation for the $468 million increase above the advance appropriations amount for medical facility activations for fiscal year 2016.

Response. See attached.

Dollars in Thousands ($000)		2016		
VISN	Project Name	Advance Approp	Revised Request	Increase/ Decrease
2	Buffalo, NY - Day Treatment Center	$0	$0	$0
2	Rochester - Outpatient ClinicLease	$2,180	$0	($2,180)
2	Syracuse - Addition For SCI Center (OV)	$0	$430	$430
3	Manhattan, NY - Hospital Restoration and Renovation	$265	$20,097	$19,832
4	Butler - Health Care CenterLease	$355	$717	$362
5	Charlotte Hall, MD - Community Based Outpatient Clinic	$84	$0	($84)
6	Charlotte - Health Care CenterLease	$8,384	$31,981	$23,597
6	Fayetteville - Health Care CenterLease	$2,116	$2,837	$721
6	Greenville NC - Outpatient ClinicLease	$0	$40,863	$40,863
6	Winston-Salem - Health Care CenterLease	$1,962	$52,698	$50,736
7	Anderson - Outpatient ClinicLease	$175	$573	$398
7	Atlanta - Specialty CareLease	$2,213	$10,199	$7,986
7	Birmingham - Clinical Annex/Outpatient ClinicLease	$3,829	$1,150	($2,679)
7	Columbus - Community-Based Outpatient ClinicLease	$726	$0	($726)
7	Hinesville - Community-Based Outpatient ClinicLease	$171	$679	$508
7	Huntsville - Outpatient ClinicLease	$3,374	$1,306	($2,068)
7	Montgomery - Health Care CenterLease	$1,004	$3,952	$2,948
7	Savannah - Community-Based Outpatient ClinicLease	$461	$0	($461)
8	Bay Pines - Inpatient/Outpatient Improvements	$0	$2,091	$2,091
8	Brandon - Outpatient Clinic (Tampa)Lease	$180	$0	($180)
8	Orlando - New Medical Facility (OV)	$19,276	$78,965	$59,689
8	San Juan - Mental Health Residential & Pyschosocial Outpatient ClinicLease	$435	$0	($435)
8	San Juan - Seismic Corrections Bldg. 1 (OV)	$497	$290	($207)
8	Tallahassee - Outpatient ClinicLease	$560	$14,227	$13,667
8	Tampa - Primary Care AnnexLease	$0	$4,436	$4,436
10	Mansfield - Satellite Outpatient ClinicLease	$0	$9,573	$9,573
11	Fort Wayne - Community Based Outpatient ClinicLease	$280	$1,584	$1,304
11	Grand Rapids - Community Based Outpatient ClinicLease	$1,161	$6,327	$5,166
11	South Bend - Community Based Outpatient ClinicLease	$3,134	$0	($3,134)
15	Columbia - Operating Suite Replacement	$0	$1,163	$1,163
15	St. Louis (JB) - Med Facility Improv & Cem Expansion (OV)	$1,616	$1,234	($382)
16	Biloxi - Restoration Of Hospital/Consolidation (OV)	$850	$1,975	$1,125
16	Fayetteville - Clinical Addition	$0	$3,568	$3,568
16	Mobile - Outpatient ClincLease	$1,202	$0	($1,202)
16	New Orleans - Restoration/Replacement Medical Facility (OV)	$24,059	$107,646	$83,587
16	Springfield - Community-Based Outpatient ClinicLease	$926	$0	($926)
17	Dallas - Spinal Cord Injury (SCI)	$1,852	$0	($1,852)
17	McAllen - Outpatient ClinicLease	$0	$670	$670
17	San Antonio - Health Care Center Lease	$0	$0	$0
17	San Antonio - Polytrauma Center, & Renovation of Exist Bldg. 1	$0	$582	$582
18	Gilbert, AZ - Community Based Outpatient Clinic	$2,114	$8,373	$6,259
19	Billings - Satellite Outpatient ClinicLease	$1,774	$7,025	$5,251
19	Colorado Springs - Community-Based Outpatient Clinic RelocationLease	$964	$3,816	$2,852
19	Denver - Replacement Medical Center Facility (OV)	$8,816	$22,917	$14,101
19	Denver, CO - Residential Treatment Facility	$0	$4,858	$4,858
19	Lakewood, CO - Community Based Outpatient Clinic	$867	$3,434	$2,567
20	Eugene - Community-Based Outpatient ClinicLease	$6,240	$7,861	$1,621
20	Salem - Community-Based Outpatient ClinicLease	$1,564	$7,742	$6,178
20	Seattle - B101 Mental Health (OV)	$0	$17,247	$17,247
20	Seattle - Correct Seismic Deficiencies B100, NT & NHCU	$10,823	$32,546	$21,723
21	Monterey - Health Care CenterLease	$1,524	$6,932	$5,408
21	Palo Alto - Centers for Ambulatory Care and Polytrauma Rehabilitation (OV)	$6,643	$3,893	($2,750)
21	San Jose - Outpatient ClinicLease	$788	$0	($788)
21	Vallejo, CA - Co-Location of CFM's Western Regional Office and VISN 21 Offi	$0	$3,162	$3,162
22	Bakersfield - Community-Based Outpatient ClinicLease	$475	$0	($475)
22	Loma Linda - Health Care CenterLease	$2,179	$9,120	$6,941
22	Los Angeles - Seismic Corrections - 12 Bldgs.	$1,902	$0	($1,902)
22	Las Vegas - New Medical Facility (OV)	$0	$57,435	$57,435
23	Knoxville, IA - Community Based Outpatient Clinic	$0	$0	$0
	TOTAL	$130,000	$598,174	$468,174

Question 13. VA cost estimates for new activations are $28 per square foot for leases and new construction and $6,600 per new employee.

a. Please provide a detailed breakdown of these cost estimates.

Response. The $28 per square foot is a GSA standard for office space IT activation, we have no further breakdown. The $6,600 breakdown is as follows:

Estimated Cost	Cost Element
$1,000	Computer
$1,200	License for Computer Software
$1,200	VOIP Phone
$800	Blackberry
$1,200	Blackberry Sustainment ($100/mo x 12 mos)
$200	Softphone Hardware/Software
$200	Softphone License
$100	Network Support ($100 per port)
$200	Wiring Infrastructure ($200 per jack)
$250	Storage and Server
$250	Email and security license
$6,600	Total

b. How do these cost estimates compare to the private sector?

Response. We have no reliable source of information for comparison to the private sector.

Question 14. Please detail the status of each of the 27 leases included in Public Law 113–146, the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act). Please provide a timeline for completion of Phases 1–4 of the leases.

Response. The table below shows the status and timeline for each of the 27 leases included in the Choice Act.

Phase	Location	Type	VISN	New or Replacement	Size (nusf)	Planned Complete Requirements Package (Project Start)	Planned SFO Approval	Planned Lease Award	Planned Acceptance	Planned First Use
Interim	Lafayette, LA	CBOC	16	Replacement	29,224	Feb-12	Jul-13	Mar-15	Sep-16	Mar-17
	Lake Charles, LA	CBOC	16	New	24,088	Feb-12	Jul-13	Sep-15	Jul-17	Jan-18
Phase 1	Cape Girardeau, MO	CBOC	15	Replacement	43,000	Oct-14	Mar-16	Mar-17	May-19	Nov-19
	Chico, CA	CBOC	21	Replacement	42,000	Oct-14	Mar-16	Mar-17	May-19	Nov-19
	Chula Vista, CA	CBOC	22	Replacement	31,000	Oct-14	Mar-16	Mar-17	May-19	Nov-19
	Johnson County, KS	CBOC	15	New	22,910	Oct-14	Mar-16	Mar-17	Nov-18	May-19
	Tyler, TX	OPC	17	Replacement	48,425	Oct-14	Mar-16	Mar-17	May-19	Nov-19
	West Haven, CT	CCC	1	Replacement	45,000	Oct-14	Mar-16	Mar-17	May-19	Nov-19
	Worcester, MA	CBOC	1	Replacement	40,000	Oct-14	Mar-16	Mar-17	May-19	Nov-19
Phase 2	Brick, NJ [1]	CBOC	3	Replacement	60,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	Charleston, SC [1]	PCA	7	Replacement	75,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	Chattanooga, TN [1]	CBOC	9	Replacement	75,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	Cobb County, GA [1]	CBOC	7	Replacement	64,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	Lincoln, NE [1]	CBOC	23	Replacement	72,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	Lubbock, TX [1]	CBOC	18	Replacement	94,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	Myrtle Beach, SC	CBOC	7	Replacement	64,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	Redding, CA [1]	CBOC	21	Replacement	77,000	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
	San Diego, CA [1]	CBOC	22	Replacement	99,986	Jan-15	Jun-16	Jun-17	Aug-19	Feb-20
Phase 3	Albuquerque, NM [1]	Research	18	Replacement	80,000	Apr-15	Sep-16	Sep-17	Nov-19	May-20
	Hines, IL [1]	Research	12	New	164,000	Apr-15	Sep-16	Sep-17	May-20	Nov-20
	Houston, TX	Research	16	Replacement	48,000	Apr-15	Sep-16	Sep-17	Nov-19	May-20
	San Antonio, TX [1]	CBOC	17	Replacement	190,800	Apr-15	Sep-16	Sep-17	May-20	Nov-20
	Phoenix, AZ [1]	OPC	18	New	203,000	Apr-15	Sep-16	Sep-17	May-20	Nov-20
Phase 4	Honolulu, HI [1]	OPC	21	New	66,000	Jul-15	Dec-16	Dec-17	Aug-20	Feb-21
	New Port Richey, FL [1]	OPC	8	Replacement	114,000	Jul-15	Dec-16	Dec-17	Aug-20	Feb-21
	Ponce, PR [1]	OPC	8	Replacement	114,300	Jul-15	Dec-16	Dec-17	Aug-20	Feb-21
	Tulsa, OK [1,2]	CBOC	16	Replacement	140,000	Jul-15	Dec-16	Dec-17	Aug-20	Feb-21

[1] Denotes projects that exceed the current General Services Administration (GSA) Prospectus threshold of $2.85 million and therefore cannot yet be delegated to the Department of Veterans Affairs (VA) by GSA. Even though Congress has already authorized these projects, GSA's Congressional committees must provide resolutions prior to GSA granting delegation.

[2] The conditions set forth in the Choice Act may make procurement of the Tulsa lease impossible to successfully complete. Additionally, the Choice Act decreases the authorized size of the Tulsa facility by approximately 30 percent from what was requested by VA. VA believes Congressional action is required in order to proceed with the project.

Question 15. The Congressional Budget Office scored the leases in section 601 of the Choice Act as direct spending. However, VA indicated 4 of the 27 leases are being funded through the $5 billion provided to increase veterans access to care in section 801 of the Choice Act. Please provide a breakdown of the funding source for each of the 27 leases.

Response. Of the 27 Major leases authorized in Section 601 of the Choice Act, 4 are new leases (Lake Charles, LA in FY 2016; Johnson County, KS in FY 2017; Phoenix, AZ in FY 2017; and Honolulu, HI in FY 2018) supporting access improvements and have supporting funding identified in the plan developed for the Section 801 funds. The remaining 23 are replacement or Research leases with support from within existing VHA appropriated funding streams.

Question 16. In the fiscal year 2016 budget, VA requested legislative language to pursue additional types of Enhanced-Use Lease (EUL) agreements beyond creating supportive housing. At least two VA Inspector General Reports in 2012 and a Government Accountability Office (GAO) report in August 2014 show that VA needs to improve how it tracks and monitors its current EUL agreements.

a. What changes has VA made to its tracking and monitoring of EUL agreements?

Response. VA has developed an agile and modernized tracking program and has made improvements to the oversight and monitoring of EUL agreements after the Inspector General (IG)'s report in 2012. VA has issued detailed and holistic guidance for the oversight and monitoring of the EUL portfolio during the post-transaction stage of the EUL lifecycle. This includes defining roles and responsibilities of EUL stakeholders, both corporately and locally at the site where the EUL resides, as well as defining recurring reviews for compliance and paths for escalation should issues arise with a particular EUL. In addition, VA has developed a new technology system (Enhanced Use-Lease Information System) to help in the tracking and monitoring of operational EULs. This technology enables improved collaboration with on-site resources and serves as a common source of information for recurring compliance tracking.

In addition to the improved oversight and tracking, VA also developed a new methodology for estimating the benefits and costs associated with the EUL program. This methodology has been in use for the past three years and the results of the methodology are published annually in VA's Congressional Budget Submission (Volume IV, EUL Consideration Report). This report provides a transparent view of the benefits to VA, Veterans, and local communities as a result of these EUL projects.

As a result of these improvements, all recommendations in the IG's report have been closed out. In regards to the GAO report in August 2014, it focused on land-use agreements, but excluded EULs from the audit. References to EUL in that report were only used to illustrate how the EUL oversight program is structured, but GAO did not actually assess the EUL program.

b. Would the system be able to handle an influx of new EULs should this legislative language become law?

Response. Yes. The enhancements made to the EUL oversight and monitoring process are fully scalable to accommodate new EULs. In addition, the Enhanced Use-Lease Information System is fully operational and capable of handling the influx of new EULs, should this legislative language become law.

Long-term care

Question 17. More than half of the veterans seeking healthcare through VA are over the age of 65. As the veterans population continues to age, the Department will be faced with challenges of chronic health conditions as well as increasing demand for long-term care services. The fiscal year 2016 budget again requests $80 million for State Veterans Homes grants, $10 million below the fiscal year 2015 appropriated level. How will the decrease in construction funding impact the availability of beds for veterans seeking long-term care through State Homes?

Response. The FY 2016 VA state home construction grant program funding request of $80M is unchanged from the FY 2015 request. The decrease in construction funding will have no impact on the current level of available state beds. However, required funding supporting FY 2016 new bed construction is not fully predictable until States have completed their application for the FY 2016 Priority List. States had until April 15, 2015, to submit new applications. VA may have funds for 1–2 new construction projects in FY 2016 dependent upon an appropriation of $80M and the total cost of FY 2016 safety projects. The availability of these new beds will be realized following completion of construction. This is typically a 2–3 year process based on project size and complexity.

Women Veterans

Question 18. The Mental Health Medical Care account for fiscal year 2016 is $7.5 billion. Please break out the amount allocated for women-only programs.

Response. The total mental health medical care amount for women Veterans in fiscal year 2016 is estimated at $700 million.

CONSTRUCTION AND CAPITAL ASSETS

Question 19. The fiscal year 2016 budget request includes $1.14 billion for major construction projects, to include nine VHA projects. The fiscal year 2015 total estimated cost of the Long Beach, CA, project was $287.1 million. The fiscal year 2016 total estimated cost for the project is now $317.3 million. What accounts for the $30.2 million increase?

Response. The construction cost increase on the Long Beach, CA project is due to building area increases to meet updated design criteria for the Community Living Center and additional cost escalation as the project waits for full construction funding.

Question 20. Of the nine VHA major construction projects requested, all but one project will need future funding in order to be completed. Please detail each of the

remaining eight projects, including a breakdown of future budget requests and projected completion dates.

Response. The completion dates of these projects are dependent on when funding is received.

Location	FY16 Budget Request ($000)	Future Budget Request ($000)	Description of Remaining Phases	# Months After to Complete Project After Receipt of Last Funding
St. Louis (Jefferson Barracks), MO	90,100	34,400	Phase 5: Cemetery Expansion	33
Louisville, KY	75,000	640,000	Phase 2: Construction of the medical center, energy plant and laundry	36
		135,000	Phase 3: VBA and parking garages	
American Lake, WA	11,000	73,700	Phase 2: Construct new Clinic (Building 201)	30
		81,100	Phase 3: Renovate Buildings 81 and 81AC	
San Francisco, CA	158,000	55,000	Phase 2: Seismic retrofit of Building 6	36
		111,220	Phase 3: Seismic retrofit of Building 1 and 8, parking structure, and demolition of Building 12	
West Los Angeles, CA	35,000	167,800	Phase 4: Renovate Buildings 156, 157, and 158	30
		32,600	Phase 5: Renovate Buildings 222 and 300	
		20,300	Phase 6: Renovate Buildings 206 and 207	
		44,600	Phase 7: Renovate Buildings 212 and 257; demolition of Buildings 114 and 115	
Long Beach, CA	161,000	30,200	Phase 3: Construct Garage and Cogeneration energy system; demolish Buildings 128, 123 and other seismically, clinically and environmentally deficient buildings	36
Alameda, CA	70,000	152,868	Phase 2: Construct new clinic, Phase 1 of the columbarium, and the Construction Management Office	36
Livermore, CA	139,000	161,000	Phase 2: Construct East Bay Outpatient Clinic and Central Valley Community Living Center	30
		27,300	Phase 3: Renovate specialty clinics at Palo Alto	
		38,000	Phase 4: Remediate/re-purpose Livermore Campus; construct Central Valley Engineering Building	

Question 21. The Advance Planning and Design Funds for VHA is projected to increase by $23.7 million or 34 percent between fiscal year 2015 and fiscal year 2016. What accounts for the $23.7 million increase? Please detail the specific projects included in this increase.

Response. VA's request for the Advanced Planning and Design Fund (APDF) line item is based on the estimated need to support a project and other requirements through this fund. The APDF provides funding for schematic design, design development, and construction document phases up to 100 percent of design for major construction projects. This allows VA to complete 35 percent of total design prior to requesting construction funds. It can be used to prepare facility master plans, historic preservation plans, conduct environmental assessments and impact studies, energy studies or audits, and design and construction-related research studies including post-occupancy evaluations. The funds are also utilized to maintain construction standards, such as: design guides and standards, specifications, and space criteria.

The table below reflects the anticipated use of the APDF in fiscal year (FY) 2016:

Location/Project Description	Planned Amounts ($000)
American Lake, WA—Buildings 81, 81AC and 18 Seismic Corrections	6,000
Bay Pines, FL—Phase 4 Renovation	1,650
Livermore, CA—Realignment and Closure, Palo Alto	5,500
Long Beach, CA—Mental Health and Community Living Center	300
Louisville, KY—New Medical Facility	2,000
Omaha, NE—Replacement Medical Facility	2,000
Palo Alto, CA—Ambulatory Care and Polytrauma Rehab	2,000
Portland, OR—Retrofit and Renovation	17,000
Roseburg, OR—Seismically Upgrade and Renovate Building 2 and Replace Building 1	5,000
San Francisco, CA—Seismic Retrofit Buildings 1,6 and 8/Replace Building 12	200
San Juan, PR—Seismic Corrections	100
St Louis, MO—Bed Tower Replacement	5,380
Tampa, FL—Polytrauma Renovation/New Bed Tower	3,200
West Los Angeles, CA—Seismic Upgrade to 12 Buildings	3,200
Pre-planning for Strategic Capital Investment Planning Projects	5,000
Historic Preservation, Environmental, Value Management, and Cost Estimating Services (Various Projects)	10,000
Facilities Standards and Criteria	11,700
Integrated Strategic Master Plans (Various Locations)	38,000
Total	$118,230

Question 22. The fiscal year 2016 budget requests $5 million for claims analyses, a $3 million or 150 percent increase over fiscal year 2015 levels. Please provide a list of the number of claims filed against VA for fiscal year 2014 and to date in fiscal year 2015. What specifically accounts for the $3 million increase?

Response. The table below lists the claims filed against VA during FY 2014 and year-to-date for FY 2015.

VA Major Construction Claims

Project	Number of Claims
FY 2014	
Abraham Lincoln National Cemetery, IL	2
Pittsburgh Consolidation Building 29 Ductwork	1
Orlando New Medical Center	4
Las Vegas Photovoltaic System	1
Palo Alto	1
Total	9
FY 2015	
Fort Jackson National Cemetery	1
New Medical Center, Aurora, CO	140
Total	141

Prior to the FY 2015 request, VA had not requested funds for this line item since FY 2009. VA's use of this line item had remained relatively limited from FY 2009 through FY 2013, averaging $98,000 per year. In FY 2014, VA used $2.2 million, and in FY 2015 to-date, VA has spent over $2 million. The growth in VA's request from

FY 2015 to FY 2016 is directly related to the recent increase in claims from the Denver Replacement Medical Center.

Question 23. In Secretary McDonald's testimony, he indicated one of his top priorities is to "right-size" VA's capital asset portfolio. He indicated that VA currently has 336 buildings that are vacant or less than 50 percent occupied, which costs VA $24 million annually to maintain and operate.

a. Please provide a list of facilities VA intends to close.

Response. The 336 buildings referenced by Secretary McDonald in his testimony do not represent facility closures. These are individual buildings, located at VA med-

ical centers across the county, that are no longer in use. Disposal of these individual buildings would not impact Veteran Services being delivered at that particular facility, but would generate significant cost savings.

At this time, there are no plans to close any VA facilities. VA is conducting a review of its facilities and considering options such as possible realignments. These realignments may result in a partial or full closure of a facility. VA stakeholders will be offered a briefing once the plan becomes final.

b. How does VA plan to dispose of excess space while ensuring that it does not affect veterans' access to care?

Response. As stated above, the 336 buildings referenced by Secretary McDonald that are presently vacant or less than 50% occupied do not represent any planned facility closure. Rather these are individual buildings which are, through a combination of age, location, need, and layout, no longer suitable for regular use by VA. Given this fact, the disposal of these excess buildings should have no impact on provision of services to Veterans as these assets are not being utilized to provide services at this time.

In cases where VA has multiple buildings that are underutilized (i.e. building is larger than need, so only a part of the building is necessary), efforts can be undertaken to consolidate the services to a single building, allowing for disposal of one or more buildings. This disposal would only occur after consolidation occurs, so again, no impact to Veteran services would be anticipated. The vacant buildings that are no longer needed for patient care will either be planned for demolition, given to a third-party developer to convert to homeless housing via VA's Enhanced Use Lease (EUL) process (subject to congressional authority), or they will remain mothballed due to historic preservation considerations. Many of these buildings are too old to efficiently house administrative services, let alone clinical services that require additional floor load, heating and ventilation requirements, upgraded electrical and plumbing, etc. Therefore, disposal of these individual buildings would not impact Veteran's services being delivered at any respective facility with these buildings.

VETERANS BENEFITS ADMINISTRATION

Question 24. In the fiscal year 2016 budget, VA requested an additional 320 employees to handle non-rating work.

a. Please provide the calculations used by VA to determine that 320 was the correct number of non-rating staff to request.

Response. VBA is grateful for the funding received in the FY 2015 and 2016 appropriations to support 420 additional non-rating FTE. VBA completed a record 3.1 million non-rating claims in FY 2015, which was a 16 percent increase over non-rating claims completed in FY 2014, and a 37 percent increase over non-rating claims completed in FY 2013. The additional 320 FTE in FY 2016 will enable VBA to continue to reduce the non-rating inventory to below 800,000 and the average time a Veteran is waiting for a non-rating decision from 345 days at the end of FY 2015 to an average of 280 days.

b. How many employees, in total, were dedicated exclusively to non-rating work during fiscal year 2014 and how many employees, in total, will be dedicated exclusively to non-rating work during fiscal year 2015?

Response. At the end of FY 2014, 789 employees were assigned to non-rating teams, including 200 temporary employees. VBA is in the process of hiring additional temporary non-rating employees utilizing the increased funding for FTE received in 2015. This will increase the number of staff dedicated to non-rating claims work to 1,009 in 2015. Receipt of VBA's FY 2016 request for funds to support an additional 320 non-rating FTE will allow VBA to retain these temporary employees, convert them to permanent positions, and also further increase non-rating staffing levels. These additional resources are expected to enable VBA to achieve a steady state of approximately 500,000 pending non-rating claims/actions in FY 2017.

c. During fiscal year 2014 and to date during fiscal year 2015, were non-rating employees required to work on the disability claims backlog during regular hours or overtime hours? If so, how many non-rating employees were used for that purpose and, on average, how many regular hours and how many overtime hours per month were worked for that purpose?

Response. All employees regardless of team assignment were required to work disability rating claims during their mandatory 20 hours of overtime each month. During fiscal year 2014, VBA's 854 non-rating full time equivalent employees (FTE) worked approximately 19 hours of overtime per month, and in fiscal year 2015, 1,059 FTE worked an average of 15 hours per month. This 20-hour per month man-

datory overtime requirement was in place from January to August 2015, with optional overtime offered in other months.

Often rating-related and non-rating related work are completed concurrently. In these cases, employees are directed to take credit for rating-related work instead of non-rating work, because the rating-related work credit is assigned the greatest point value in VBA's performance management system. Employees are instructed to work all associated actions on a pending claim, but may not take dual credit for both rating and non-rating work accomplished by the same action. On average, disability rating claim work was approximately 20 to 25 percent of our non-rating FTEs' work completed in fiscal years 2014 and 2015 during their regular tour of duty, which averages to 22 to 28 hours per month per employee.

d. What metrics does VA use to determine the actual and expected productivity per employee for non-rating staff?

Response. Non-rating claims generally include adjustments to existing compensation and pension awards that are processed after the initial award of benefits. As more rating claims are processed in FY 2015 and more Veterans begin receiving compensation and pension benefits, there will be a similar increase in non-rating claims.

In addition to completing 1.32 million disability rating claims in Fiscal Year 2014, VBA also completed 2.7 million non-rating claims and other administrative actions, a 30 percent increase from FY 2012. Productivity increased from 147.2 non-rating claims/actions per FTE in FY 2012, to 188.7 claims/actions in FY 2014. Using the FY 2015 staffing level of 14,765 direct FTE, VBA's non-rating production is currently 206.8 claims/actions per compensation and pension direct FTE. In addition to claims processing personnel, direct FTE includes all employees supporting compensation and pension programs, such as fiduciary employees, national call center employees, outreach personnel, military services coordinators, etc. This does not include management support, which typically comprises 11 percent of all compensation and pension field staff.

VBA continues to focus on the body of non-rating work while we simultaneously eliminate the rating claims backlog As VBA hires additional staff to address non-rating work, VBA will track non-rating productivity as well as monitor the inventory of these claims as the primary metrics for our improvement efforts.

e. Using those metrics, what was the productivity per non-rating employee during fiscal year 2014 and what is the productivity per non-rating employee to date during fiscal year 2015?

Response. VBA does not budget field FTE solely for rating or non-rating work. Production per FTE is based on all compensation and pension employees assigned to each regional office's claims processing workforce. Please see the chart below with FY 2015 FTE prorated for five months (14,479 direct FTE ceiling divided by 12 months and then multiplied by five months):

	FTE	Non-Rating Claim and Administrative Actions Completed	Non-Rating Production per FTE
FY 2014	14,307	2,699,264	188.7
FY 2015 (February)	6,033	1,247,695	206.8

f. What would be the expected level of individual productivity for non-rating staff, if the fiscal year 2016 budget is adopted?

Response. VBA forecasts that the additional 320 non-rating employees would complete 145,000 to 165,000 non-rating claims/administrative actions in FY 2016. However, the number of non-rating claims completed per FTE will initially decrease because of the hours devoted to training the new employees and the lower production levels of these employees due to their inexperience. Production per FTE for budgetary purposes is based on all compensation and pension FTE assigned to claims processing in all regional offices, not just FTE processing non-rating claims. In FY 2016, VBA expects non-rating claim production per FTE to decrease slightly from the current average of 206 non-rating claims/actions per compensation and pension FTE.

g. What would be the expected timeline for bringing these new non-rating employees on board, if the fiscal year 2016 budget is adopted?

Response. The 320 additional non-rating FTE will be hired in the first quarter of FY 2016.

h. How would these new non-rating employees be allocated among the regional offices?

Response. The new non-rating employees will be placed in a few regional offices based on available seating. However, these additional employees will be a national resource focused on challenged workload areas within the non-rating workload of all regional offices, such as drill pay adjustments and dependency claims.

i. Please provide any goals or milestones the Veterans Benefits Administration (VBA) has established for reducing the number of pending non-rating work items, including an estimation of when the level of pending work will be reduced to a level that VBA considers acceptable.

Response. VBA's success in completing rating decisions has driven an increase in non-rating claims. Despite completing a 20-year record number of non-rating claims in FY 2014, this work continues to grow. In FY 2015, VBA expects to receive 2.9 million non-rating claims and other administrative review actions, an increase of 7.4 percent over 2014 (2.7 million) and 20.8 percent over 2013 (2.4 million). These additional resources are expected to continue to reduce the non-rating inventory in FY 2016 and enable VBA to achieve a steady state of approximately 500,000 pending non-rating claims/actions in FY 2017.

j. During the remainder of fiscal year 2015 and during fiscal year 2016, will regional offices be permitted to use overtime hours to deal with non-rating work?

Response. FY 2015 compensation and pension overtime efforts are focused on the following priorities: backlog rating claims, priority rating claims (Medal of Honor recipients, prisoners of war, homeless Veterans, Veterans with hardship, terminally ill Veterans, fully developed claims, etc.), and functions in support of continued transformation into a paperless environment, such as centralized mail. For the remainder of FY 2015, VBA will continue to focus on the abovementioned priorities during overtime efforts. In FY 2016, overtime use will be reassessed by VBA leadership.

k. During fiscal year 2016, does VBA intend to use the services of any contractors to assist with non-rating work? If so, how much is expected to be expended on those contractors and what level of productivity is expected to be achieved as a result of use of those contractors?

Response. On April 21, 2014, VA awarded a contract for assistance in entering data from paper-based dependency claims into VA's electronic rules-based processing system. The contractor enters the information from the paper-based dependency claims just as a claimant would enter information if filing the claim online using eBenefits. The performance period is one base-year and two option-years. During FY 2016, VA will continue to utilize the contract to assist in reducing the inventory of dependency claims. In FY 2016, funds for this contract total $3.1 million, with approximately 400,000 dependency claim reviews projected to be completed by the contractor. Because not all claims reviewed by the contractor can be fully processed to completion through VA's online rules-based processing system, manual processing of the more complex dependency claims is still required.

Question 25. In the fiscal year 2016 budget, VA requested an additional 200 employees to work on appeals.

a. Please provide the calculations used by VA to determine that 200 was the correct number of appeals employees to request.

Response. VBA is grateful for funding in FY 2015 and FY 2016 to hire another 300 appeals FTE. However, these additional FTE are not sufficient to address the existing or future appeals workload. Under the appeals framework established by current law, Veterans are waiting far too long for final resolution of their appeals. Legislation is needed to streamline and modernize the appeals process. The 300 FTE will assist VA in closing the gap, but without legislative change or significantly greater increases in staffing, VA will face a soaring appeals inventory, and Veterans will wait even longer for a decision on their appeal.

In the FY 2017 President's Budget, VA sets forth a plan to provide most Veterans with a timely and fair decision on their appeal within one year of filing the appeal. VA looks forward to working with Congress to secure the required resources to address the current appeals workload and the legislative changes needed to provide Veterans with a modern appeals process.

b. How many employees, in total, were dedicated exclusively to appeals during fiscal year 2014 and how many employees, in total, will be dedicated exclusively to appeals during fiscal year 2015?

Response. In FY 2014, VBA had 11,290 claims processors on board, of which 950 employees were dedicated to processing appeals in regional offices and 190 employees at the Appeals Management Center. In FY 2015, VBA is dedicating the same level of resources to appeals. Additionally in FY 2014 all of the Board of Veterans'

Appeals 631 employees were dedicated to processing appeals and in FY 2015all 642 employees were dedicated to processing appeals.

c. During fiscal year 2014 and to date during fiscal year 2015, were appeals employees required to work on the disability claims backlog during regular hours or overtime hours? If so, how many appeals employees were used for that purpose and, on average, how many regular hours and how many overtime hours per month were worked for that purpose?

Response. In FY 2014 nd FY 2015 appeals processors have been focused on appeals workload. During this same period all appeals processors were on mandatory overtime and required to complete 20 hours of overtime per month.

d. What metrics does VA use to determine the actual and expected productivity per employee for appeals employees?

Response. Production per FTE is based on all compensation and pension employees assigned to regional offices. As VBA continues to receive and complete record-breaking numbers of disability rating claims in recent years (1.32 million claims completed in 2014), the volume of appeals increases concomitantly. Using the FY 2015 staffing level of 14,765 direct FTE, VBA's appeals productivity is currently 11.4 appeal actions (e.g., statements of the case, appeal certifications) per FTE. As VBA hires additional FTE to address appeals, VBA will track production, inventory, and average days pending as the primary metrics of improvement efforts.

e. Using those metrics, what was the productivity per appeals employee during fiscal year 2014 and what is the productivity per appeals employee to date during fiscal year 2015?

Response. The complex appeal process defined in law involves multiple reviews of the evidence considered in the original decision as well as any new evidence received during the appeal. Please see the chart below for VBA's total completed appeal actions (e.g., statements of the case, appeal certifications) and appeals productivity:

	VBA FTE	Appeal Actions Completed	Appeals Productivity
FY 2014	14,307	176,991	12.4
FY 2015 (February)	6,033	69,073	11.4

f. What would be the expected level of individual productivity for appeals staff, if the fiscal year 2016 budget is adopted?

Response. VBA's key metrics for measuring appeals processing is the completed appeal actions, inventory of notices of disagreement (NODs), and the average days pending for this workload. In the first year, VBA projects the completed appeal actions and appeal resolutions will increase, while productivity per FTE will slightly decrease as the new appeals employees become familiar with the entire appeals process. By the end of the second year, productivity per FTE will return to the current level, approximately 11 completed appeal actions per compensation and pension direct FTE. As previously noted, productivity per FTE is based on all compensation and pension employees assigned to regional offices, not just FTE processing appeals.

To increase efficiency, VBA is working closely with the Board of Veterans' Appeals, Veterans Service Organizations, and Congress to identify legislative solutions to simplify the appeals process and improve the timeliness of appeal decisions.

g. What would be the expected timeline for bringing these new employees on board, if the fiscal year 2016 budget is adopted?

Response. In February of FY 2015, VBA had 11,290 appeal claim processors on board, including approximately 950 employees dedicated to processing appeals in regional offices and 190 employees at the Appeals Management Center. VBA is in the process of adding 100 appeal claim processor FTE in FY 2015, and as soon as full funding is provided in FY 2016, VBA will hire 200 additional appeal claim processor FTE.

h. How would these new appeals employees be allocated among the regional offices?

Response. VBA's Resource Allocation Model (RAM) is a systematic approach to distributing field resources each fiscal year. RAM utilizes a weighted model to assign compensation and pension FTE resources based on regional office workload which takes into account the following factors:

- number of rating claims pending
- number of rating claims received,
- number of non-rating claims received

- and the number of appeals

Starting in FY 2014, RAM incorporated additional variables that align with VBA's transformation to a paperless environment, where receipts can be assigned and managed at the national level. These variables include:

- station efficiency (claims completed per FTE)
- quality
- each regional office's processing capacity

VBA uses the model as a guide and makes adjustments for special circumstances or missions performed by individual regional offices. Special missions include:

- Appeals Management Center
- Benefits Delivery at Discharge processing
- Integrated Disability Evaluation System (IDES) processing
- Quick Start processing
- National Call Centers (NCCs)
- foreign claims processing
- radiation processing
- Camp Lejeune Contaminated Water (CLCW) processing
- and Pension Management Centers (PMCs).

i. Please provide any goals or milestones VBA has established for reducing the number of pending appeals, including an estimation of when the level of pending work will be reduced to a level that VBA considers acceptable.

Response. Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA continues to receive and complete record-breaking numbers of disability rating claims in recent years (1.3 million claims completed in FY 2014), the volume of appeals increases concomitantly. The number of statements of the case and other appellate actions completed by VBA on Veterans' appeals has increased 31 percent since 2011, from 135,000 actions to 177,000 actions. VBA currently has approximately 290,000 pending appeals.

VBA is working to reduce its pending appeals inventory to less than one year of receipts by the end of FY 2017. In addition, VA is engaging with its key partners and stakeholders to define and establish the levels of service delivery that Veterans should be able to expect in the appeal process and determine what legislative and resource changes would be needed to meet those expectations.

j. During the remainder of fiscal year 2015 and during fiscal year 2016, will regional offices be permitted to use overtime hours to handle pending appeals?

Response. In FY 2015 appeals processors were dedicated to working appeals only during regular hours. VBA utilized overtime in both a voluntary and mandatory capacity at various times in FY 2015 for all claims processors, including those working appeals. However, during overtime, appeals processors were focused on the following prioritization targets: backlog claims and priority claims (Medal of Honor recipients, prisoners of war, homeless Veterans, Veterans with hardship, terminally ill Veterans, fully developed claims, etc.). Overtime use in FY 2016 is being reassessed by VBA leadership.

Question 26. In the fiscal year 2016 budget, VA requests an additional 85 fiduciary field examiners.

a. Please provide the calculations used to determine that 85 was the correct number of fiduciary employees to request.

Response. In FY 2014, VBA's fiduciary program protected more than 172,800 beneficiaries, which is a 41 percent increase in the number of beneficiaries from 2011 (122,271). An increase in the total number of beneficiaries receiving VA benefits and an aging population are the primary causes for this program growth. With this dramatic increase, the fiduciary program's current staffing levels are inadequate to properly oversee all beneficiaries. If sufficient resources are not provided, beneficiary protection will be compromised with increased intervals between visits.

From 2011 to 2014, the field FTE allocation increased 22 percent (703 FTE to 855 FTE); however, staffing has not kept pace with program growth. Even though fiduciary hubs are completing more work through FTE increases and recent efficiencies, the backlog of pending field examinations continues to grow. The following chart reflects the 19 percent growth in completed field examinations and the 16 percent growth in pending field examinations experienced between 2012 and 2014.

Field Examination Workload	FY12	FY13	FY14
Completed			
Initial Appointment	40,816	44,563	47,789
Follow-up Field Examinations	27,485	34,642	34,669
Follow-up Alternate Field Examinations	2,891	3,745	2,380
Total Field Examinations Completed	71,192	82,950	84,838
Pending			
Initial Appointment	10,130	7,020	7,370
Follow-up Field Examinations	24,469	26,496	33,367
Follow-up Alternate Field Examinations	1,348	919	1,102
Total Field Examinations Pending	35,947	34,435	41,839

In July of FY 2014, VBA notified Congress of a need to hire 1,618 FTE, including 307 FTE to address the increase in fiduciary workload. VBA is grateful for funding in FY 2015 to hire 50 fiduciary FTE and is asking for funding in FY 2016 to hire an additional 85 fiduciary FTE.

b. This information is included in the budget request for fiscal year 2016: "In May 2014, VBA began the process of evaluating the current performance standards for field personnel by conducting a work measurement study of all fiduciary work tasks. This study is under contract and should be completed in June 2015." Once that study is complete, will VBA re-evaluate the required number of employees for fiscal year 2016?

Response. Yes, VBA will use data collected through the Work Measurement Study (WMS) to refine fiduciary program resource requirements. The fiduciary program has experienced tremendous growth and significant revisions to policies and procedures. The WMS is capturing work performance in the new fiduciary environment. With the information provided through the WMS, VBA will more accurately define and quantify the time involved in completing fiduciary program work.

Question 27. In volume 3 of the fiscal year 2016 budget request, a chart on page VBA–205 indicates that, in fiscal year 2013, VBA received 168,745 work items labeled as "compensation rating other" and, in fiscal year 2014, VBA received 568,057 work items with that label. That chart also reflects that, in fiscal year 2013, VBA received 1.1 million work items labeled as "compensation non-rating other" and, in fiscal year 2014, VBA received 666,898 work items with that label.

a. What factors account for the large change in the number of these types of work items received in those years?

Response. The two tables referenced from the FY 2016 budget request regarding claims received and completed both have errors. In the FY 2015 budget request, similar tables attempted to explain the distribution of claims received and completed in different categories to provide a different perspective of VBA's workload. This year's budget table incorrectly kept the row descriptions and FY 2013 column from last year's budget narrative. The corrected tables to replace the ones on page VBA–205 are provided below:

Received Claims	2013	2014	2015 Estimate	2016 Estimate
Compensation Rating	897,396	963,834	1,135,905	1,231,617
Compensation Non-Rating	484,735	568,057	632,360	651,331
Compensation Controlled End Products	642,573	731,274	807,070	830,759
Compensation Other End Products	584,742	666,898	710,454	731,767
Total Compensation Workload	2,609,446	2,930,063	3,285,789	3,445,474

Completed Claims	2013	2014	2015 Estimate	2016 Estimate
Compensation Rating	1,017,513	1,145,607	1,212,597	1,230,819
Compensation Non-Rating	410,775	528,495	694,228	708,113
Compensation Controlled End Products	572,620	727,443	656,180	666,804
Compensation Other End Products	554,974	633,614	713,225	729,944

Completed Claims	2013	2014	2015 Estimate	2016 Estimate
Total Compensation Workload Actions	2,555,882	3,035,159	3,276,230	3,335,679

b. Were there any changes in how VBA categorizes this work?

Response. As noted in the response above, the tables in the FY 2016 budget request are different from those shown in the FY 2015 budget request. VBA reverted to the traditional four groupings of compensation work products, as defined in the narrative found on page VBA–205. The figures presented in the above tables are corrected based on the same definitions.

c. Please enumerate the specific types of work included in each category.

Response. The FY 2016 budget narrative, on page VBA–205, discusses the four groupings of compensation work, including:

1. *Compensation Rating:* Original disability claims with eight or more contentions or medical conditions or with seven or fewer contentions; supplemental disability claims; as well as requests for future medical exams
2. *Compensation Non-Rating:* Dependency determinations that impact the entitlement of the Veteran or his dependents/family members; and other adjudicated decisions that impact entitlement to other VA or Federal programs
3. *Compensation Controlled End Products:* Controlled correspondence with a Veteran or beneficiary not requiring additional rating or authorization decisions; required reviews of claims; and corrections of claims
4. *Compensation Other End Products:* Verification of continued eligibility or status; Freedom of Information Act and Privacy Act requests; special correspondence involving Members of Congress or other U.S. Government agencies; notices of upcoming determinations or reviews that could affect a Veteran's status; eligibility for vocational rehabilitation services; and other administrative actions

Question 28. In response to pre-hearing questions, VA stated that $122.8 million had been expended on overtime hours during fiscal year 2014 to process compensation and pension claims and that VBA has expended $37 million for that purpose to date during fiscal year 2015.

a. How much is VA requesting for fiscal year 2016 for overtime hours to process compensation and pension claims?

Response. Of the $55 million requested for overtime in FY 2016, VBA currently anticipates using approximately $47 million to fund overtime for compensation and pension claims processing.

b. Please provide the number of claims (not issues) completed during overtime hours during fiscal year 2014 and the number of claims (not issues) expected to be completed during overtime hours during fiscal years 2015 and 2016.

Response. VBA completes an estimated 1,700 rating claims for every $1 million of invested overtime funding. Based on this calculation, in FY 2014, an estimated 208,000 claims were completed due to the additional overtime funding. In FY 2015, VBA estimates completing an additional 127,500 claims with the budgeted $75 million overtime funding. In FY 2016, VBA budgeted approximately $50 million for overtime directed toward the completion of disability claims. This will allow VBA to complete an additional 85,000 claims in FY 2016.

Question 29. In November 2014, GAO issued a report outlining certain shortcomings with VBA's quality assurance program related to claims processing. What changes are planned in response to that report, what is the timeline for implementing those changes, and what level of funding is requested for fiscal year 2016 in relation to those changes?

Response. In response to GAO's recommendations, VBA is making numerous changes to the quality assurance program, including:

- Beginning with claims completed in January of FY 2015, VBA executed a revised sample methodology that uses each regional office's output and claims processing accuracy to determine the number of cases reviewed. No additional funding is required at this time.
- Claims are being reviewed based upon the regional office that worked the claim, which eliminates deselection of claims that are transferred to another regional office for processing. Reporting of these claims will include the confidence intervals for each regional office. VBA will ensure this work, known as "brokered work," is not underrepresented in quality reviews. No additional funding is required at this time.
- VBA is currently drafting an abstract describing our sampling, assessment criteria, accuracy calculation, and reporting methodologies for claim and issue-level ac-

curacy. This abstract will accompany future performance documents and public reports to explain key differences between the claim-based and issue-based accuracy rates.

- VBA is utilizing a Knowledge Management portal to make all guidance and reference materials available to claims processors. This portal will include the Adjudication Procedures Manual, M21–1, as well as other interim guidance in one searchable location. This project is being funded with existing resources and is expected to become functional within the current fiscal year.
- VBA is currently designing a new system that will incorporate all types of quality reviews, to include local regional office reviews, Systematic Technical Accuracy Review (STAR), and consistency studies, which will capture data at various stages of the claims process. This system will provide VBA with increased data analysis capabilities for accuracy review and improved tracking of error trends.

Question 30. In recent years, Congress has provided funding for a number of initiatives to improve VBA's ability to handle its claims workload, including the Veterans Benefits Management System, eBenefits, and the Stakeholder Enterprise Portal.

a. Are there any initiatives that are not yet having the expected impact on productivity? If so, please quantify the future increases in productivity expected as a result of these initiatives.

Response. VBA is retraining, reorganizing, streamlining business processes, and building and implementing technology solutions based on the newly redesigned processes to improve benefits delivery. VBA expects several transformation initiatives, as described below, to continue increasing the number of claims and issues completed per FTE. It is difficult to extract the impact of each transformation initiative from the combined people, process, and technology models that are being concurrently implemented to determine individual initiatives' contribution to productivity outcomes.

VBA's transformation progress is the result of an integrated series of initiatives designed to eliminate the backlog. The FY 2016 budget will allow VBA to continue building on the success of the following initiatives:

Veterans Claims Intake Program (VCIP): VCIP streamlines processes for receiving digital records and data into the Veterans Benefits Management System (VBMS) and other VBA systems, transitioning VBA from a paper-based claims environment to a digital operating environment. It scans paper claims, converts them into digital format, and extracts important data for input into electronic folders. VCIP has converted and uploaded more than 1.3 billion images from paper. In addition to supporting scanning operations for incoming claims, VBA's FY 2016 request of $140.8 million will allow the digital intake of military, income, and employment records from other Federal agencies and private providers. This will broaden electronic evidence exchange for processing all types of claims more accurately and more rapidly by building additional interfaces for Official Military Personnel Folders (OMPF) from DOD and interfaces with health networks, hospitals, and private clinicians.

Centralized Mail: Centralized mail consolidates inbound paper mail from VA's ROs to a centralized intake site. This initiative expands VBA's capabilities for scanning and conversion of claims evidence, increases electronic processing capabilities, and assists in converting 100 percent of received source materials to electronic format. VBA has deployed centralized inbound mail for all ROs. The FY 2016 budget request of $18.3 million provides resources to sustain operations at all 56 ROs and positions VBA to expand centralized mail operations to other lines of business and centralize outbound correspondence to Veterans.

Veterans Benefits Management System: VBMS, as VBA's key business transformation initiative, provides a paperless claims-processing environment and improved business processes to support timely, high-quality decisions for Veterans and their dependents. National deployment of VBMS was completed June of FY 2013 and provides access to over 28,000 end users. VBMS allows VBA to centrally manage the claims workload at the national level and direct cases electronically across its network of ROs to more efficiently match claims demand with available processing capacity. VBA went from touching 5,000 tons of paper annually to now processing 95 percent of the claims inventory electronically in VBMS. VBA has now completed over 1.32 million claims in VBMS. In FY 2015, VBMS is focused on delivering the National Work Queue (NWQ) and reducing reliance on legacy systems. In FY 2016, VBMS enhancements will focus on the Integrated Disability Evaluation System, appeals, and pension.

National Work Queue: VBA will distribute claims electronically from a centralized queue based on RO capacity using the electronic NWQ, a national workload man-

agement strategy. With all claims placed in the electronic NWQ, Veterans' claims will be automatically directed across all ROs to efficiently match claim demand with available expertise and processing capacity regardless of RO jurisdiction, delivering benefits to Veterans more quickly and accurately. The electronic inventory provides real-time updates, no matter where the claim is assigned for processing. Veterans are still able to receive assistance with their claims by visiting their RO for personal assistance at the public contact sites, going on-line through eBenefits, and utilizing VBA's National Call Centers. In FY 2016, VBA is requesting $3.2 million to provide the requisite funding to resource and support 13 employees to manage the NWQ across the VBA enterprise.

Veterans Relationship Management: The VRM initiative continues to facilitate an increasingly more Veteran-centric digital operating environment. VRM is delivering a scalable, enterprise-wide, services-based technology environment that will be the foundation for how Veterans are served and how benefits and services are delivered. This new model will provide VA an integrated services delivery platform with the approach of placing the Veteran at the center of the service with all business requirements and design being driven from the Veteran perspective.

Components of VRM include eBenefits, the Stakeholder Enterprise Portal (SEP), Customer Relationship Management solutions, Digits-to-Digits, Knowledge Management, and Veterans Online Application Direct Connect. Through the eBenefits portal, Veterans can submit claims for benefits, administer their accounts, and receive status updates. The eBenefits Web portal standardizes claim intake and enables collaboration with VSOs to assist Veterans with all interactions with VA. VA continues to expand the capabilities available through the eBenefits portal as more Veterans use the site. Today eBenefits has 4.4 million registered users and over 48 million visits annually. VBA's FY 2016 request for $13.8 million, in addition to the $67 million requested for VRM in the Office of Information Technology, will support ongoing operations and continued efforts to pilot and deploy new solutions for VBA mobile applications that expand access to self-service tools and benefits/services information in VBA portal environments; develop new service features in SEP for medical providers, loan officers, fiduciaries, and funeral directors; and integrate VetSuccess with Career Center for Veterans, enabling searches for jobs posted by unique employers targeting Veterans.

b. What metrics does VA utilize to determine whether overall efficiency is improving as a result of those investments? Do those metrics take into account the percent of work completed during overtime rather than during regular hours?

Response. Through VBA's claims transformation initiatives, the number of claims completed per compensation and pension direct FTE increased 25 percent from 2012 to 2014. An even more accurate representation of VBA's increase in productivity is seen at the medical issue-level rather than the claim-level. From 2009 to 2014, VBA's issue-level productivity increased by 67 percent.

It is difficult to extract the impact of each transformation initiative from the combined people, process, and technology models that are being concurrently implemented to determine individual initiatives' contribution to productivity outcomes. The productivity metrics include work completed on overtime.

Question 31. The fiscal year 2016 budget request includes a proposal to limit the circumstances under which VA is required to provide a medical examination for a veteran seeking disability compensation. Under that proposal, an examination would be provided by VA only if there is "objective evidence establishing that the Veteran experienced an event, injury, or disease during military service." VA estimates that this change would lead to cost savings of $438 million over 10 years.

a. Please provide any available statistics on how frequently disability claims are ultimately granted in the circumstances where an examination has been provided even though the veteran did not have such objective evidence. Alternatively, please provide any statistics on how frequently a claim is ultimately denied under those circumstances.

Response. VA does not maintain data regarding grant rates based on specific evidence that may or may not have been present. After separation from service and with the passage of time, the rate VA denies service-connected disability significantly increases. In FY 2013, VA denied 42 percent of issues for conditions that were not caused by service for Veterans who submitted claims within one year of discharge; 66 percent of issues submitted by Veterans who filed a claim between 10 and 20 years after discharge were denied on this basis. While claimants from both categories were provided medical examinations to support their claims, the disproportionate number of denials seen when a claim is filed longer after separation suggests a large portion of medical examinations were scheduled unnecessarily.

b. Please provide the calculations and assumptions used to determine the estimated cost savings of this initiative.

Response. The methodology to calculate cost savings was based on data showing claims with an exam request that were denied because a disability was not incurred in or caused by service or because there was no diagnosis. Based on this data, VA assumed 30 percent of an estimated 166,000 exams would result in a denial of claimed conditions being associated with Veterans' military service. An estimated 75 percent of these denied exams could be presumed as savings under this proposal since an exam would not be warranted.

GENERAL ADMINISTRATION

Question 32. The Office of Small and Disadvantaged Business Utilization's (OSDBU), Center for Verification and Evaluation (CVE) is charged with verifying veteran businesses looking to take advantage of veteran specific VA contracting preferences. There have been legislative proposals presented to move CVE outside of VA or to another office under the Secretary.

a. What are VA's views of proposals to move CVE to another Federal agency and is the current organization best positioned to verify veteran businesses?

Response. VA does not support moving CVE to another agency. CVE is responsible for verifying the eligibility of VOSBs for the VA Veterans First procurement preference program under 38 U.S.C. § 8127. We do not believe it appropriate to have important elements of a VA program performed by other agencies. CVE is best positioned to verify Veteran businesses as it resides in the Office of Small and Disadvantaged Business Utilization, the organization responsible for promoting Veteran access to contracting opportunities within VA. Since the primary benefit of verification is to establish eligibility for VA contracting opportunities, having the CVE verification function within OSDBU appropriately places these closely related functions together.

b. Additionally, it has been suggested that other agencies do not have the infrastructure in place to verify veteran businesses. What analysis has VA performed on the budgetary implications of instituting a governmentwide certification program for veterans in terms of cost and FTEs required?

Response. There are no comparable authorities and thus no comparable programs within the Federal Government. VA's verification program is unique among government programs, although the closest comparable programs are found within SBA. SBA has an SDVOSB program and the 8(a) business development program. However, while the SBA's SDVOSB program has similar regulations to VA's, entry into the program is based on self-certification rather than an up-front verification of eligibility of all applicants. SBA reviews SDVOSB eligibility only if a protest is filed by an interested party against a prospective awardee, and only a very small percentage of SDVOSBs are ever actually reviewed to ensure compliance.

Second, while the 8(a) program does review its applicants before granting admittance to the program, the requirements are different, and concerns "age out" of the program. For example, since the 8(a) program provides business development assistance, the program requires applicants to show potential for success. Government and private sector contracts are awarded to an 8(a) firm as part of the participant's business plan for development. These criteria have no counterpart in the VA verification program. The 8(a) program therefore not only sees far fewer applications, but it also deals with a significantly smaller database of participants at any time.

By contrast the VA has increased its infrastructure capacity, to include professional development and training as well as contract and legal support. VA has also refined and documented its processes. VA's current processes are appropriate for replication and scale. VA has not done analysis of the budgetary implications of a governmentwide verification program as the Administration has not established a position on such a program. Should a decision be made on governmentwide verification, we believe that it would be most cost-effective to scale up the CVE program by obtaining additional personnel to cover the workload and apply already-existing processes and criteria, rather than creating new infrastructure in other agencies.

c. Does VA have the capability to administer a governmentwide certification program or would a more effective verification program be housed outside of VA?

Response. VA's VOSB verification program has the capability to rapidly increase and support the scale of a governmentwide program expansion. VA could obtain additional personnel to cover the workload and apply already-existing processes and criteria, whereas other agencies would have to develop these capabilities.

d. What estimates does VA have of the current cost per applicant to CVE and what are VA's estimates of those costs government wide?

Response. The estimated average cost to process one application through CVE in FY 2015 is $1,242. We do not have an estimate of these costs governmentwide. As noted previously, no other agency has a similar verification function that can be used as a comparison.

Question 33. The chart, "Summary of Employment and Obligations," for the Office of Acquisitions and Logistics Supply Fund does not include FTE information specifically for CVE.

a. Please provide the Committee with the FTE requirements for CVE for fiscal year 2016 and the preceding three years.

Response. The number of Federal FTE in CVE for the period 2013–2016: 2013: 16 2014: 17 2015: 17 (one position vacant) Projected 2016: 21 (Requested addition of 4 Federal staff to review evaluations).

b. Please provide the Committee with a detailed budget for OSDBU and CVE.

Response. The FY 2015 Budget for OSDBU and CVE is provided below:

2015 Approved Budget
As of 05/07/2015

	(000s of dollars)	
	CVE	All OSDBU
FTE	17	42
Obligations:		
FTE	$2,471	$6,660
Professional Services	$7,387	$17,214
Travel	$30	$102
Training	$15	$54
Printing and reproduction	$1	$30
Contract Support	$5,843	$7,183
Supplies and materials	$8	$48
Equipment	$2	$80
Rents	$301	$523
Security	$20	$52
Total obligations	[1] $16,078	[2] $31,946

[1] CVE budget includes an increase in budget authority of $4.511 million for contract support and professional services since January 2015.
[2] OSDBU budget reflects the increases in CVE budget and an additional authorization for non-CVE items of $1.736 million

INFORMATION TECHNOLOGY

Question 34. In the fiscal year 2016 budget, VA is proposing raising from $1 million to $3 million "the threshold at which a request is required [to] be made from both Houses of Congress prior to the transfer of funds between projects."

a. Please provide further explanation for this request and what specific projects would require a transfer of funds.

Response. Under current law, VA's IT Systems appropriations account is divided into three subaccounts—pay/administration, operations and maintenance, and development. The development subaccount is further divided into a number (roughly a dozen) project lines. Each subaccount and each project line are assigned a certain amount of funds. During the course of the year as funds are executed, an under execution of funds may occur for a variety of reasons; proper stewardship suggests that these under-executed funds be reprogrammed to other high priority needs. Historically, the annual appropriations act has included language requiring that VA request and receive the approval of the Committees on Appropriations of both Houses of Congress before reprogramming funds among the three subaccounts and/or shifting funds among development projects. The requirement has remained constant over the years, while the IT Systems appropriations account has grown significantly. This modest increase in the threshold at which permission must be sought for reprogramming will allow for more effective management of resources within the IT Systems Account.

b. Please provide a list of all transfer of funds VA has requested for Information Technology (IT) projects for the past two fiscal years.

Response. The Re-programming letters for both FY 2013 and FY 2014 are attached, and include a list of projects that required funding transfers.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
May 30, 2013

The Honorable Mark Kirk
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Senator Kirk:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to reprogram and transfer funds provided in the Consolidated and Further Continuing Appropriations Act, 2013 (Public Law (P.L.) 113-6) for Information Technology (IT) systems. The proposal would:

- Transfer $24.2 million to the development, modernization, and enhancement (DME) subaccount and $20.5 million to the operations and maintenance subaccount with the total of $44.7 million coming from the pay and administration subaccount;
- Increase or decrease the cost of 12 DME projects by more than $1,000,000; and
- Reallocate funds among the Department's approved list of 17 DME projects to ensure that VA has the necessary resources to support its highest priorities.

In addition, we are planning to use $27.7 million of authorized carryover funds that were made available for DME in the Consolidated Appropriations Act, 2012 (P.L. 112-74) for DME projects that will be executed in 2013. The reprogramming does not change the total appropriation for IT systems and is consistent with the information provided in the President's 2014 Budget for IT in 2013. The enclosed narrative and table provide details of the planned reprogramming by subaccount and for projects within the DME total.

For several reasons, funds are available for reprogramming in the pay and administration subaccount of the IT systems appropriation. Reasons such as the payroll spending restraint exercised by VA when the Office of Information and Technology (OIT) operated under interim funding provided by the 2013 Continuing Resolution; reprioritization of IT contract support; and reduced travel spending will allow

VA to carry out administrative requirements at a reduced funding level in 2013 with no adverse effects. Funds are available for reprogramming in the operations and maintenance subaccount because OIT has realized cost avoidances in the competitive pricing and expenditures on various contracts and agreements.

VA's investment in IT is essential to achieving the President's goals to end Veteran homelessness, eliminate the claims backlog, and expand access to benefits and services. VA's investment in IT supports the consistent delivery of benefits and services to Veterans and their dependents. To provide high-quality care, VA must sustain a reliable, national IT infrastructure that encompasses 151 medical centers, 827 community-based outpatient clinics, 300 Vet centers, 57 regional benefit offices, 131 national cemeteries, and other support facilities.

A similar letter has been sent to the other leaders of the House and Senate Committees on Appropriations and Veterans' Affairs. Thank you for your continued support of our mission.

Sincerely,

Eric K. Shinseki

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
May 30, 2013

The Honorable Tim Johnson
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

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The Honorable Tim Johnson

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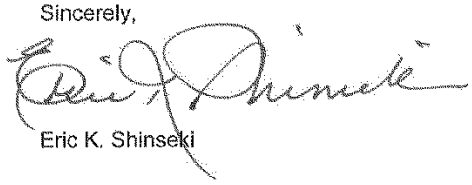
Sincerely,



Eric K. Shinseki

Enclosures

Department of Veterans Affairs (VA)
2013 Reprogramming Highlights

VA's fiscal year (FY) 2013 reprogramming provides net increases of $24.2 million to systems development, modernization, and enhancement (DME) and $20.5 million to sustainment with the total of $44.7 million coming from pay and administration. The realigned funds will support and implement the Secretary's highest priority information technology (IT) initiatives and critical operational needs. The details of these funding realignments are summarized below and provided in the funding realignment table.

Within the DME subaccount, the reprogramming among programs and projects provides increased funding for the following:

- **Veterans Benefits Management System (VBMS).** Increased VBMS funding of $15.2 million will support development enhancements to eliminate the claims backlog. This includes the overall rating work needed to complete the Evaluation Builder, Simplified Notification Letter, and Disability Benefit Questionnaire as well as provides the foundational pieces for scanning hardware hosting to support auto-extraction, validation, and rules generation.

- **New Models of Care.** Increased funding of $5.9 million will support additional development of telehealth modalities for better access to health care.

- **Other IT Development.** A net increase of $72.6 million will support critical programs and projects, which include:

    - **Pharmacy Systems Reengineering (PRE) Project.** Additional funds of $14.5 million for PRE will advance development and improvement of software to assist with modernization, standardization, and interoperability of the national and local drug file used by VA pharmacies. The integrated Electronic Health Record (iEHR) will need local pharmacy sites to migrate and map to a common drug file. It also advances PRE's drug order checking software to check more drug order aspects that will reduce potential harm to patients. This software is planned to be made available by PRE as a service to the iEHR Enterprise Service Bus in FY 2014, which will make these improved drug order checking capabilities available earlier to iEHR pharmacies for integrated use.

    - **Electronic Data Interchange (EDI) New Standards and Operating Rules.** Additional funds of $12.8 million to implement new standards and operating rules for eInsurance, eBilling, ePharmacy, and ePayments & eBilling Claims Compliance. EDI provider operating rules are required under the Patient Protection and Affordable Care Act regulation, Section 1104. Compliance with the new standards and operating rules ensures VA will continue to optimize the efficiency of revenue and collection.

    - **Innovations – Veterans Affairs Center of Innovation.** Additional funds of $12.7 million are required to identify, develop, test, and potentially

implement new technologies and approaches to improve patient care and safety. Some of the innovations include automated radiology (RAPTOR) that optimizes advanced medical imaging protocols; Alert Watch & Response Engine (ALERT) which provides automated tools for clinicians to monitor and track Computerized Patient Record System alerts on patients; and mobile eBenefits to provide Veterans with mobile device tools for timely and convenient benefits delivery.

- **Chapter 33, GI Bill Enhancements**. Additional funds of $4.4 million are required for development of enhanced Veteran education benefit capabilities.

- **Veterans Affairs Intranet Quorum Replacement**. Additional funds of $4.0 million to replace the existing VA correspondence tracking and management system due to privacy, security, and functionality deficiencies.

- **Sterile Processing Service Scope Action Plan (ISO-9000)**. Additional funds of $4.0 million to bring Veterans Health Administration facilities in compliance with existing policy directives and standards for quality management of reusable medical equipment. This will mitigate problems identified in a Government Accountability Office audit of improper cleaning and sterilization of endoscopes.

- **Safety Updates for Medication/Prescription Management**. Additional funds of $3.7 million to enhance and improve patient safety in delivering medications/prescriptions to Veterans.

- **Other Projects Net**. On net, additional funds of $16.5 million are provided for safety and security, various medical registries, data integration, and other DME projects.

- **Remaining Projects with Minimal Funding Changes**. Net funding of $4.4 million is provided for seven development projects with changes under $5 million, including: Health Care Efficiency, Homelessness, Virtual Lifetime Electronic Record, Health Management Platform, ICD-10, VHA Research Support, and Integrated Operating Model.

Also within the DME subaccount, the reprogramming among programs and projects reflects the reduced funding for the following:

- **Access to Healthcare IT Development**. Funding is reduced by $36.9 million to realign funds to support higher priority DME projects for VBMS and patient care and safety.

- **Veterans Relationship Management**. Funding is reduced by $12.6 million to realign funds to support higher priority DME projects for VBMS and patient care and safety.

- **Surgical Quality and Workflow Management Development**. Funding is reduced by $7.2 million to better align funding with project budget execution.

- **Human Capital Development.** Funding is reduced by $6.4 million because of higher priority DME requirements.

- **VA Learning Management Systems Development**. Funding is reduced by $5.5 million because of higher priority DME requirements.

- **Pay/Administration**. Funding is reduced by $44.7 million. During the 6-month continuing resolution, the Office of Information Technology (OIT) was held to about $450 million, the pro-rated FY 2012 appropriation level. This funding level significantly restricted OIT's ability to hire and replace staff. Uncertainty about the final FY 2013 appropriation level forced OIT managers to plan for the entire year at the FY 2012 level. Thus, staffing was suppressed across the organization.

Department of Veterans Affairs
Fiscal Year (FY) 2013 of Information and Technology (IT) Systems
FY 2013 Reprogramming
(Dollars in Thousands)

	FY 2012/2013 Baseline Plan	Reprogram-Net Total	FY 2012/2013 Revised Plan	FY 2013/2014 Baseline Plan	Reprogram-Net Total	FY 2013/2014 Revised Plan	Original 12/13 & 13/14 Total Annual Execution Plan	Revised 12/13 & 13/14 Total Annual Execution Plan	Delta
Total Budget Authority									
Development									
Access to Healthcare IT Development	$ -	$ -	$ -	$ 40,260	$ (36,963)	$ 3,297	$ 40,260	$ 3,297	$ (36,963)
Surgical Quality and Workflow Management Development	$ -	$ -	$ -	$ 27,467	$ (7,165)	$ 20,302	$ 27,467	$ 20,302	$ (7,165)
Healthcare Efficiency IT Development	$ -	$ -	$ -	$ 4,653	$ 4,084	$ 8,737	$ 4,653	$ 8,737	$ 4,084
Homelessness IT Development	$ -	$ -	$ -	$ 3,071	$ (279)	$ 2,792	$ 3,071	$ 2,792	$ (279)
Integrated Electronic Health Record (IEHR)	$ 8,125	$ -	$ 8,125	$ 103,863	$ -	$ 103,863	$ 111,988	$ 111,988	$ -
Mental Health IT Development	$ -	$ -	$ -	$ 8,806	$ (5,325)	$ 3,481	$ 8,806	$ 3,481	$ (5,325)
New Models of Care IT Development	$ -	$ -	$ -	$ 35,677	$ 5,908	$ 41,585	$ 35,677	$ 41,585	$ 5,908
Veterans Benefits Management Systems (VBMS)	$ -	$ -	$ -	$ 38,474	$ 15,161	$ 53,635	$ 38,474	$ 53,635	$ 15,161
Virtual Lifetime Electronic Record (VLER)	$ -	$ -	$ -	$ 49,873	$ (567)	$ 49,307	$ 49,873	$ 49,307	$ (567)
Veterans Relationship Management (VRM)	$ -	$ -	$ -	$ 96,091	$ (12,558)	$ 83,533	$ 96,091	$ 83,533	$ (12,558)
Health Management Platform Development	$ -	$ -	$ -	$ 7,490	$ 10	$ 7,500	$ 7,490	$ 7,500	$ 10
International Classification of Diseases - 10 Development	$ -	$ -	$ -	$ 11,485	$ 4,679	$ 16,164	$ 11,485	$ 16,164	$ 4,679
VHA Research IT Support Development	$ -	$ -	$ -	$ 18,497	$ (2,850)	$ 15,646	$ 18,497	$ 15,646	$ (2,850)
Human Capital Development	$ -	$ -	$ -	$ 9,088	$ (6,368)	$ 2,720	$ 9,088	$ 2,720	$ (6,368)
Integrated Operating Model	$ -	$ -	$ -	$ 14,081	$ (668)	$ 13,413	$ 14,081	$ 13,413	$ (668)
VA Learning Management Systems Development	$ -	$ -	$ -	$ 5,533	$ (5,533)	$ 0	$ 5,533	$ 0	$ (5,533)
Other IT Development	$ 19,544	$ -	$ 19,544	$ 19,338	$ 72,607	$ 91,945	$ 38,882	$ 111,489	$ 72,607
Subtotal	$ 27,669	$ -	$ 27,669	$ 493,747	$ 24,174	$ 517,921	$ 521,416	$ 545,590	$ 24,174
Sustainment/O&M									
Medical Operations and Maintenance		$ -	$ -	$ 748,028	$ 17,752	$ 765,779	$ 748,028	$ 765,779	$ 17,752
Benefits Operations and Maintenance		$ -	$ -	$ 207,722	$ 274	$ 207,996	$ 207,722	$ 207,996	$ 274
Enterprise Operations and Maintenance		$ -	$ -	$ 756,569	$ 2,324	$ 758,893	$ 756,569	$ 758,893	$ 2,324
Interagency Operations and Maintenance	$ 1,941	$ -	$ 1,941	$ 97,335	$ 129	$ 97,464	$ 99,276	$ 99,405	$ 129
Subtotal	$ 1,941	$ -	$ 1,941	$ 1,809,654	$ 20,479	$ 1,830,132	$ 1,811,595	$ 1,832,073	$ 20,479
Development	$ 27,669	$ -	$ 27,669	$ 493,747	$ 24,174	$ 517,921	$ 521,416	$ 545,590	$ 24,174
Sustainment/O&M	$ 1,941	$ -	$ 1,941	$ 1,809,654	$ 20,479	$ 1,830,132	$ 1,811,595	$ 1,832,073	$ 20,479
Staffing and Administration	$ 3,569	$ -	$ 3,569	$ 1,019,653	$ (44,653)	$ 975,000	$ 1,023,222	$ 978,569	$ (44,653)
H1N1 Supplemental (P.L. 111-32)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
OEF/OIF Supplemental (P.L. 110-28)	$ 247	$ -	$ 247	$ -	$ -	$ -	$ 247	$ 247	$ -
Total	$ 33,426	$ -	$ 33,426	$ 3,323,053	$ 0	$ 3,323,053	$ 3,356,479	$ 3,356,479	$ 0

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	FY 2012/2013 Baseline Plan	Reprogram-Net Total	FY 2012/2013 Revised Plan	FY 2013/2014 Baseline Plan	Reprogram-Net Total	FY 2013/2014 Revised Plan	Original 12/13 & 13/14 Total Annual Execution Plan	Revised 12/13 & 13/14 Total Annual Execution Plan	Delta
Access to Healthcare IT Development	$ -	$ -	$ -	$ 40,260	$ (36,963)	$ 3,297	$ 40,260	$ 3,297	$ (36,963)
Access IT - Program Management Office	$ -	$ -	$ -	$ 1,180	$ (1,181)	$ (0)	$ 1,180	$ (0)	$ (1,181)
Clinical Flow management (CDM)	$ -	$ -	$ -	$ 1,686	$ (1,686)	$ (0)	$ 1,686	$ (0)	$ (1,686)
Emergency Department Information System Development	$ -	$ -	$ -	$ 3,695	$ (3,695)	$ 0	$ 3,695	$ 0	$ (3,695)
Veterans Benefits Handbook Development	$ -	$ -	$ -	$ 3,793	$ (3,793)	$ (0)	$ 3,793	$ (0)	$ (3,793)
Veterans Transportation	$ -	$ -	$ -	$ 4,047	$ (4,047)	$ (0)	$ 4,047	$ (0)	$ (4,047)
Annual Surgery Updates	$ -	$ -	$ -	$ 548	$ (548)	$ (0)	$ 548	$ (0)	$ (548)
ASIH Bed Hold	$ -	$ -	$ -	$ 2,276	$ (2,276)	$ (0)	$ 2,276	$ (0)	$ (2,276)
Bed Management Solutions	$ -	$ -	$ -	$ 6,549	$ (3,252)	$ 3,297	$ 6,549	$ 3,297	$ (3,252)
Intensive Care Unit/Anesthesia Record Keeper (ICU/ARK) Analytics System	$ -	$ -	$ -	$ 5,901	$ (5,901)	$ 0	$ 5,901	$ 0	$ (5,901)
(NUMI) National Utilization Management Integration-Development	$ -	$ -	$ -	$ 1,686	$ (1,686)	$ (0)	$ 1,686	$ (0)	$ (1,686)
VPS Kiosk Development	$ -	$ -	$ -	$ 4,215	$ (4,215)	$ 0	$ 4,215	$ 0	$ (4,215)
Access to Care Received Closer to Home	$ -	$ -	$ -	$ 3,934	$ (3,934)	$ (0)	$ 3,934	$ (0)	$ (3,934)
Veterans Implant Tracking System (VITAS)	$ -	$ -	$ -	$ 749	$ (749)	$ 0	$ 749	$ 0	$ (749)
Surgical Quality and Workflow Management Development	$ -	$ -	$ -	$ 27,467	$ (7,165)	$ 20,302	$ 27,467	$ 20,302	$ (7,165)
Surgery Quality Workflow Manager	$ -	$ -	$ -	$ 27,467	$ (7,165)	$ 20,302	$ 27,467	$ 20,302	$ (7,165)
Healthcare Efficiency IT Development	$ -	$ -	$ -	$ 4,653	$ 4,084	$ 8,737	$ 4,653	$ 8,737	$ 4,084
Beneficiary Travel	$ -	$ -	$ -	$ 1,657	$ (1,657)	$ (0)	$ 1,657	$ (0)	$ (1,657)
Facility Automation	$ -	$ -	$ -	$ 2,996	$ (2,948)	$ 48	$ 2,996	$ 48	$ (2,948)
Non-VA Care Claims Processing	$ -	$ -	$ -	$ -	$ 5,189	$ 5,189	$ -	$ 5,189	$ 5,189
Real Time Location System (RTLS) National Middleware Data Repository	$ -	$ -	$ -	$ -	$ 3,500	$ 3,500	$ -	$ 3,500	$ 3,500
Homelessness IT Development	$ -	$ -	$ -	$ 3,071	$ (279)	$ 2,792	$ 3,071	$ 2,792	$ (279)
Homelessness Case Management Development	$ -	$ -	$ -	$ 1,498	$ (1,498)	$ 0	$ 1,498	$ 0	$ (1,498)
Analytical Tool	$ -	$ -	$ -	$ 250	$ (250)	$ 0	$ 250	$ 0	$ (250)
Homelessness Management Information System	$ -	$ -	$ -	$ 999	$ 751	$ 1,751	$ 999	$ 1,751	$ 752
Web-based Management Models-Development (Web based Models, including Grants Management System)	$ -	$ -	$ -	$ 325	$ (325)	$ 0	$ 325	$ 0	$ (325)
Handheld Device for Homeless Program	$ -	$ -	$ -	$ -	$ 1,041	$ 1,041	$ -	$ 1,041	$ 1,041
Integrated Electronic Health Record (iEHR)	$ 8,125	$ -	$ 8,125	$ 103,863	$ -	$ 103,863	$ 111,988	$ 111,988	$ -
Integrated Electronic Health Record	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Identity Management Services	$ -	$ -	$ -	$ 8,911	$ -	$ 8,911	$ 8,911	$ 8,911	$ -
Presentation Services	$ -	$ -	$ -	$ 48,868	$ -	$ 48,868	$ 48,868	$ 48,868	$ -
Immunization Specific Services	$ -	$ -	$ -	$ 2,784	$ -	$ 2,784	$ 2,784	$ 2,784	$ -
Laboratory Specific Services	$ -	$ -	$ -	$ 12,530	$ -	$ 12,530	$ 12,530	$ 12,530	$ -
Pharmacy Specific Services	$ -	$ -	$ -	$ 10,024	$ -	$ 10,024	$ 10,024	$ 10,024	$ -
Access Control Services	$ 8,125	$ -	$ 8,125	$ 3,341	$ -	$ 3,341	$ 11,466	$ 11,466	$ -
VLER Health	$ -	$ -	$ -	$ 17,404	$ -	$ 17,404	$ 17,404	$ 17,404	$ -
Mental Health IT Development	$ -	$ -	$ -	$ 8,806	$ (5,325)	$ 3,481	$ 8,806	$ 3,481	$ (5,325)
Behavioral Health Lab Software	$ -	$ -	$ -	$ 1,510	$ (561)	$ 949	$ 1,510	$ 949	$ (561)
Mental Health Clinical Reminders	$ -	$ -	$ -	$ 311	$ (311)	$ 0	$ 311	$ 0	$ (311)
Mental Health System Enhancements	$ -	$ -	$ -	$ 1,796	$ 255	$ 2,051	$ 1,796	$ 2,051	$ 255
Patient Record Flags for Suicide Risk and Missing	$ -	$ -	$ -	$ 618	$ (618)	$ 0	$ 618	$ 0	$ (618)

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	FY 2012/2013 Baseline Plan	Reprogram-Net Total	FY 2012/2013 Revised Plan	FY 2013/2014 Baseline Plan	Reprogram-Net Total	FY 2013/2014 Revised Plan	Original 12/13 & 13/14 Total Annual Execution Plan	Revised 12/13 & 13/14 Total Annual Execution Plan	Delta
Pharmacy Legacy (National Clozapine Coordination)	$ -	$ -	$ -	$ 2,475	$ (2,475)	$ 0	$ 2,475	$ 0	$ (2,475)
Clozapine Coordination)	$ -	$ -	$ -	$ 2,097	$ (2,097)	$ 0	$ 2,097	$ 0	$ (2,097)
My Recovery Plan	$ -	$ -	$ -	$ -	$ 481	$ 481	$ -	$ 481	$ 481
New Models of Care IT Development	**$ -**	**$ -**	**$ -**	**$ 35,677**	**$ 5,908**	**$ 41,585**	**$ 35,677**	**$ 41,585**	**$ 5,908**
PCCM Re-engineering	$ -	$ -	$ -	$ 1,997	$ (1,997)	$ 0	$ 1,997	$ 0	$ (1,997)
CRS Notification Abnormal Test Results	$ -	$ -	$ -	$ 949	$ (949)	$ 0	$ 949	$ 0	$ (949)
Program Management Office	$ -	$ -	$ -	$ 999	$ (999)	$ 0	$ 999	$ 0	$ (999)
VA/DoD Image and Scanned Document Sharing Phase I	$ -	$ -	$ -	$ 1,983	$ (1,983)	$ 0	$ 1,983	$ 0	$ (1,983)
VistA Imaging Core DICOM Services Phase I	$ -	$ -	$ -	$ 2,851	$ (2,851)	$ 0	$ 2,851	$ 0	$ (2,851)
VistA Imaging Display and Capture Enhancement Phase I	$ -	$ -	$ -	$ 1,733	$ (1,733)	$ 0	$ 1,733	$ 0	$ (1,733)
VistA Imaging Storage Infrastructure	$ -	$ -	$ -	$ 1,598	$ (1,598)	$ 0	$ 1,598	$ 0	$ (1,598)
VistA Imaging Storage Management Enhancements Phase I	$ -	$ -	$ -	$ 442	$ (442)	$ 0	$ 442	$ 0	$ (442)
Woman's Health Proposed Projects Development	$ -	$ -	$ -	$ 949	$ (949)	$ 0	$ 949	$ 0	$ (949)
e-Move	$ -	$ -	$ -	$ 799	$ (799)	$ 0	$ 799	$ 0	$ (799)
Health Risk Assessment	$ -	$ -	$ -	$ 1,997	$ (1,997)	$ 0	$ 1,997	$ 0	$ (1,997)
My HealtheVet Capabilities Enhancement	$ -	$ -	$ -	$ 2,297	$ (2,297)	$ (0)	$ 2,297	$ (0)	$ (2,297)
Patient Health Record (PHR) On-Line Viewing	$ -	$ -	$ -	$ 4,045	$ (4,045)	$ (0)	$ 4,045	$ (0)	$ (4,045)
Secure Messaging	$ -	$ -	$ -	$ 2,121	$ (2,121)	$ 0	$ 2,121	$ 0	$ (2,121)
Clinical Video Teleconferencing (General Telehealth)	$ -	$ -	$ -	$ 2,000	$ (2,000)	$ 0	$ 2,000	$ 0	$ (2,000)
Home Telehealth	$ -	$ -	$ -	$ 6,008	$ (6,008)	$ 0	$ 6,008	$ 0	$ (6,008)
TeleMedicine (Store-Forwards)	$ -	$ -	$ -	$ 1,959	$ (1,959)	$ 0	$ 1,959	$ 0	$ (1,959)
Breast Cancer Registry	$ -	$ -	$ -	$ 949	$ (949)	$ (0)	$ 949	$ (0)	$ (949)
Telehealth Modalities	$ -	$ -	$ -	$ -	$ 10,620	$ 10,620	$ -	$ 10,620	$ 10,620
Care Coordination - Patient Advocacy and Women's Health	$ -	$ -	$ -	$ -	$ 4,776	$ 4,776	$ -	$ 4,776	$ 4,776
Enterprise Mobile	$ -	$ -	$ -	$ -	$ 10,063	$ 10,063	$ -	$ 10,063	$ 10,063
My HealtheVet Suite	$ -	$ -	$ -	$ -	$ 16,122	$ 16,122	$ -	$ 16,122	$ 16,122
Veterans Benefits Management System (VBMS)	**$ -**	**$ -**	**$ -**	**$ 38,474**	**$ 15,161**	**$ 53,635**	**$ 38,474**	**$ 53,635**	**$ 15,161**
VBMS	$ -	$ -	$ -	$ 20,655	$ 14,787	$ 35,442	$ 20,655	$ 35,442	$ 14,787
VETSNET	$ -	$ -	$ -	$ 17,819	$ (181)	$ 17,638	$ 17,819	$ 17,638	$ (181)
Data Management Architecture Services (DMAS)	$ -	$ -	$ -	$ -	$ 555	$ 555	$ -	$ 555	$ 555
Virtual Lifetime Electronic Record (VLER)	**$ -**	**$ -**	**$ -**	**$ 49,873**	**$ (567)**	**$ 49,307**	**$ 49,873**	**$ 49,307**	**$ (567)**
Bidirectional Health Information Exchange	$ -	$ -	$ -	$ 6,491	$ (6,491)	$ 0	$ 6,491	$ 0	$ (6,491)
HHS - CONNECT Gateway	$ -	$ -	$ -	$ 3,576	$ (3,576)	$ 0	$ 3,576	$ 0	$ (3,576)
NHIN-Direct	$ -	$ -	$ -	$ 2,453	$ (2,453)	$ 0	$ 2,453	$ 0	$ (2,453)
NHIN-Direct MS	$ -	$ -	$ -	$ 4,439	$ (4,439)	$ 0	$ 4,439	$ 0	$ (4,439)
NHIN Gateway and Adaptor Development	$ -	$ -	$ -	$ 12,939	$ (12,939)	$ (0)	$ 12,939	$ (0)	$ (12,939)
VLER EPMO	$ -	$ -	$ -	$ 1,679	$ (1,679)	$ (0)	$ 1,679	$ (0)	$ (1,679)
Memorial Affairs Legacy	$ -	$ -	$ -	$ 4,993	$ (4,993)	$ 0	$ 4,993	$ 0	$ (4,993)
Memorial Affairs Legacy Redesign	$ -	$ -	$ -	$ 5,992	$ (5,992)	$ 0	$ 5,992	$ 0	$ (5,992)
Laboratory Data Sharing Initiative (LDSI)	$ -	$ -	$ -	$ 488	$ (488)	$ 0	$ 488	$ 0	$ (488)
VistAWeb Performance & User Interface	$ -	$ -	$ -	$ 1,329	$ (1,330)	$ (0)	$ 1,329	$ (0)	$ (1,330)
VLER IT PMO	$ -	$ -	$ -	$ 5,493	$ (5,493)	$ (0)	$ 5,493	$ (0)	$ (5,493)
VLER Core	$ -	$ -	$ -		$ 27,057	$ 27,057	$ -	$ 27,057	$ 27,057
VLER Benefits	$ -	$ -	$ -	$ -	$ 8,500	$ 8,500	$ -	$ 8,500	$ 8,500
VLER Memorials	$ -	$ -	$ -	$ -	$ 13,750	$ 13,750	$ -	$ 13,750	$ 13,750

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Veterans Relationship Management	$ -	$ -	$ -	$ 96,091	$ (12,558)	$ 83,533	$ 96,091	$ 83,533	$ (12,558)
Veterans Relationship Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Enterprise Veterans Self Service	$ -	$ -	$ -	$ 37,568	$ (12,458)	$ 25,111	$ 37,568	$ 25,111	$ (12,458)
Customer Relationship Management	$ -	$ -	$ -	$ 27,258	$ 352	$ 27,611	$ 27,258	$ 27,611	$ 352
Voice Access Modernization	$ -	$ -	$ -	$ 6,255	$ (251)	$ 6,004	$ 6,255	$ 6,004	$ (251)
Identity and Access Management	$ -	$ -	$ -	$ 14,713	$ (216)	$ 14,497	$ 14,713	$ 14,497	$ (216)
Fiduciary Benefits System	$ -	$ -	$ -	$ 2,527	$ 3	$ 2,530	$ 2,527	$ 2,530	$ 3
Military Service Data Sharing	$ -	$ -	$ -	$ 7,770	$ 11	$ 7,781	$ 7,770	$ 7,781	$ 11
Health Management Platform Development	$ -	$ -	$ -	$ 7,490	$ 10	$ 7,500	$ 7,490	$ 7,500	$ 10
International Classification of Diseases - 10 Development	$ -	$ -	$ -	$ 11,485	$ 4,679	$ 16,164	$ 11,485	$ 16,164	$ 4,679
VHA Research IT Support Development	$ -	$ -	$ -	$ 18,497	$ (2,850)	$ 15,646	$ 18,497	$ 15,646	$ (2,850)
Point of Care Randomization	$ -	$ -	$ -	$ 77	$ (77)	$ 0	$ 77	$ 0	$ (77)
Research Resources	$ -	$ -	$ -	$ 7,400	$ (7,400)	$ 0	$ 7,400	$ 0	$ (7,400)
Genomic Information System for Integrative Service (GenISIS)	$ -	$ -	$ -	$ 3,188	$ 23	$ 3,211	$ 3,188	$ 3,211	$ 23
Research Administrative Mgmt. System (RAMS)	$ -	$ -	$ -	$ -	$ 6,995	$ 6,995	$ -	$ 6,995	$ 6,995
Veteran Informatics & Computing Infrastructure	$ -	$ -	$ -	$ 7,832	$ (2,392)	$ 5,440	$ 7,832	$ 5,440	$ (2,392)
Human Capital Development	$ -	$ -	$ -	$ 9,088	$ (6,368)	$ 2,720	$ 9,088	$ 2,720	$ (6,368)
Child Care Records Management System	$ -	$ -	$ -	$ 999	$ (999)	$ (0)	$ 999	$ (0)	$ (999)
HR Academy Web Portal	$ -	$ -	$ -	$ 1,498	$ (1,498)	$ 0	$ 1,498	$ 0	$ (1,498)
Performance Management System	$ -	$ -	$ -	$ 999	$ (999)	$ (0)	$ 999	$ (0)	$ (999)
SES Internal Management Tracking System	$ -	$ -	$ -	$ 499	$ (499)	$ 0	$ 499	$ 0	$ (499)
Shared Service Center	$ -	$ -	$ -	$ 1,498	$ (1,498)	$ 0	$ 1,498	$ 0	$ (1,498)
VA for VETS	$ -	$ -	$ -	$ 1,848	$ 872	$ 2,720	$ 1,848	$ 2,720	$ 872
Web HR 50 Integration	$ -	$ -	$ -	$ 1,498	$ (1,498)	$ 0	$ 1,498	$ 0	$ (1,498)
Workforce Planning	$ -	$ -	$ -	$ 250	$ (250)	$ 0	$ 250	$ 0	$ (250)
Integrated Operating Model	$ -	$ -	$ -	$ 14,081	$ (668)	$ 13,413	$ 14,081	$ 13,413	$ (668)
Budget Tracking Tool (BTT)	$ -	$ -	$ -	$ 300	$ (300)	$ 0	$ 300	$ 0	$ (300)
CRM (VA FMS)	$ -	$ -	$ -	$ 4,494	$ (4,494)	$ 0	$ 4,494	$ 0	$ (4,494)
IT Product Delivery Support	$ -	$ -	$ -	$ 4,993	$ (4,993)	$ 0	$ 4,993	$ 0	$ (4,993)
Project Management Accountability System (PMAS) Dashboard	$ -	$ -	$ -	$ 1,298	$ 1,833	$ 3,131	$ 1,298	$ 3,131	$ 1,833
VA Time and Attendance Systems (VATAS)	$ -	$ -	$ -	$ 2,996	$ 1,835	$ 4,831	$ 2,996	$ 4,831	$ 1,835
Human Resource Information System (HRIS)	$ -	$ -	$ -	$ -	$ 5,450	$ 5,450	$ -	$ 5,450	$ 5,450
VA Learning Management Systems Development	$ -	$ -	$ -	$ 5,533	$ (5,533)	$ 0	$ 5,533	$ 0	$ (5,533)
Other IT Development	$ 19,544	$ -	$ 19,544	$ 19,338	$ 72,607	$ 91,945	$ 38,882	$ 111,489	$ 72,607
Disability Exam and Assessment Program (DEAP)	$ -	$ -	$ -	$ -	$ 949	$ 949	$ -	$ 949	$ 949
Enterprise Systems Integration	$ -	$ -	$ -	$ -	$ 4,902	$ 4,902	$ -	$ 4,902	$ 4,902
Enterprise Architecture Support	$ -	$ -	$ -	$ -	$ 3,500	$ 3,500	$ -	$ 3,500	$ 3,500
Computerized Patient Records System	$ -	$ -	$ -	$ -	$ 2,503	$ 2,503	$ -	$ 2,503	$ 2,503
Certification of VistA for Meaningful Use	$ -	$ -	$ -	$ -	$ 1,066	$ 1,066	$ -	$ 1,066	$ 1,066
EDI New Standards Operating Rules	$ -	$ -	$ -	$ -	$ 12,780	$ 12,780	$ -	$ 12,780	$ 12,780
Safety Updates for Medication/Prescription Management	$ -	$ -	$ -	$ -	$ 3,690	$ 3,690	$ -	$ 3,690	$ 3,690
Bar Code Expansion Positive Patient Identification	$ 1,400	$ -	$ 1,400	$ -	$ 1,900	$ 1,900	$ 1,400	$ 3,300	$ 1,900
Pharmacy Systems Reengineering Project	$ -	$ -	$ -	$ -	$ 14,548	$ 14,548	$ -	$ 14,548	$ 14,548

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VA Medication Reconciliation	$ -	$ -	$ -	$ -	$ 1,000	$ 1,000	$ -	$ 1,000	$ 1,000
VAIQ	$ -	$ -	$ -	$ -	$ 4,000	$ 4,000	$ -	$ 4,000	$ 4,000
eDiscovery	$ -	$ -	$ -	$ -	$ 1,000	$ 1,000	$ -	$ 1,000	$ 1,000
VA Website	$ -	$ -	$ -	$ -	$ 600	$ 600	$ -	$ 600	$ 600
SPS Scope Action Plan (ISO-9001)	$ 600	$ -	$ 600	$ -	$ 3,980	$ 3,980	$ 600	$ 4,580	$ 3,980
Innovations (VAIQ/VACI)	$ -	$ -	$ -	$ -	$ 12,710	$ 12,710	$ -	$ 12,710	$ 12,710
Enrollment System Modernization/Affordable Care Act	$ 2,400	$ -	$ 2,400	$ -	$ 1,601	$ 1,601	$ 2,400	$ 4,001	$ 1,601
Health Provider Systems	$ -	$ -	$ -	$ -	$ 2,700	$ 2,700	$ -	$ 2,700	$ 2,700
Medical 21st Century Scheduling	$ 7,200	$ -	$ 7,200	$ -	$ -	$ -	$ 7,200	$ 7,200	$ -
Process Management (ProPath)	$ -	$ -	$ -	$ 2,831	$ (2,831)	$ 0	$ 2,831	$ 0	$ (2,831)
HHS - Federal Health Architecture (FHA)	$ -	$ -	$ -	$ 2,088	$ (2,088)	$ 0	$ 2,088	$ 0	$ (2,088)
Repositories Development	$ 2,744	$ -	$ 2,744		$ -	$ -	$ 2,744	$ 2,744	$ -
ESR	$ -	$ -	$ -	$ 3,217	$ (3,217)	$ (0)	$ 3,217	$ (0)	$ (3,217)
Development of FMS software	$ -	$ -	$ -	$ 130	$ (130)	$ (0)	$ 130	$ (0)	$ (130)
Customer Service (survey & SLA programs)	$ -	$ -	$ -	$ 2,996	$ (2,996)	$ 0	$ 2,996	$ 0	$ (2,996)
Safety and Security Initiative (PIV)/Integrated Operating Center	$ -	$ -	$ -	$ 3,021	$ 3,464	$ 6,485	$ 3,021	$ 6,485	$ 3,464
Strategic Capital Investment Planning Database Development	$ -	$ -	$ -	$ 999	$ 1	$ 1,000	$ 999	$ 1,000	$ 1
STDP/EWCA	$ -	$ -	$ -	$ 4,057	$ (2,924)	$ 1,133	$ 4,057	$ 1,133	$ (2,924)
VHA Registries	$ -	$ -	$ -		$ 3,410	$ 3,410	$ -	$ 3,410	$ 3,410
Prosthetics Enhancements					$ 288	$ 288	$ -	$ 288	$ 288
CPTMS	$ -	$ -	$ -	$ -	$ 1,500	$ 1,500	$ -	$ 1,500	$ 1,500
Finance Center Recertification	$ -	$ -	$ -	$ -	$ 300	$ 300	$ -	$ 300	$ 300
Chapter 33 - Automated GI Bill Enhancements	$ -	$ -	$ -		$ 4,400	$ 4,400	$ -	$ 4,400	$ 4,400
Camp Lejune	$ 5,200	$ -	$ 5,200		$ -	$ -	$ 5,200	$ 5,200	$ -
Grand Total	**$ 27,669**	$ -	**$ 27,669**	**$ 493,747**	**$ 24,174**	**$ 517,921**	**$ 521,416**	**$ 545,590**	**$ 24,174**

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable Tim Johnson
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

The transfer and reprogramming would provide additional funding for critical DME projects and ensure that VA has the necessary resources to support its highest priority programs. It would not change the total 2014 appropriation for IT systems or the funding required for the pay and administration subaccount. Funds are available for reprogramming in the operations and maintenance subaccount because VA realized cost avoidance in competitive pricing and experienced lower-than-budgeted costs for various sustainment contracts and agreements.

VA's investment in IT supports the delivery of high-quality benefits and health care to Veterans, their families, and Survivors. It is critical to achieving the priority goals to eliminate the disability claims backlog and expand Veteran access to benefits and services. To provide additional information on this transfer, I have enclosed VA's reprogramming highlights and a funding realignment table by budget line item.

A similar letter has been sent to the other leaders of the House and Senate Committees on Appropriations and Veterans' Affairs. Thank you for your continued support of our mission.

Sincerely,

Sloan D. Gibson
Acting Secretary

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable Mark Kirk
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Senator Kirk:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

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Acting Secretary

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable John Culberson
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

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Acting Secretary

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable Sanford D. Bishop, Jr.
Ranking Member
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Bishop:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

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Sloan D. Gibson
Acting Secretary

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable Bernard Sanders
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

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Sloan D. Gibson
Acting Secretary

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable Richard M. Burr
Ranking Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Burr:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

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Sloan D. Gibson
Acting Secretary

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

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Sincerely,

Sloan D. Gibson
Acting Secretary

Enclosures

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 9, 2014

The Honorable Michael H. Michaud
Ranking Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Michaud:

This letter is to notify you of the intent of the Department of Veterans Affairs (VA) to transfer $43.3 million of FY 2014 Information Technology (IT) systems funds provided in the Consolidated Appropriations Act, 2014 (Public Law 113-76), from the operations and maintenance subaccount to the development, modernization, and enhancement (DME) subaccount. In addition, VA is proposing to reprogram $4.2 million within the DME subaccount. The proposal would fund essential programs and DME requirements that have emerged since the submission of the President's 2014 Budget request and ensure that VA deploys its IT resources effectively and efficiently.

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Sloan D. Gibson
Acting Secretary

Enclosures

Enclosure 1

Department of Veterans Affairs
Information Technology Systems
2014 Transfer Request Highlights

The Department of Veterans Affairs (VA) fiscal year (FY) 2014 transfer and reprogramming request would provide a net increase of $43.3 million to the Information Technology (IT) systems development, modernization and enhancement (DME) subaccount. Funds would be provided through a transfer from the operations and maintenance subaccount. In addition, $4.2 million would be reprogrammed within the DME subaccount. The realigned funds will support and implement the Secretary's highest priority IT initiatives. The details of these funding realignments are summarized below and provided in the accompanying FY 2014 Reprogramming table.

1. **Veterans Benefits Management System (VBMS): Accelerated Automation of Workflow and Workload Management - $10.0 Million**

Increased funding of $10.0 million is required to accelerate the delivery of workload and workflow management functionality for VBMS. VBA is working towards the goal of national workload distribution, and the VBMS Program Management Office (PMO) is supporting the mission and vision of the VBA Office of Field Operations (OFO) in the development of the National Work Queue (NWQ). The NWQ will offer the capabilities and processes for a more streamlined overall claims production, effectively managing the workload centrally, prioritizing and distributing the claims electronically across its network of Regional Offices (ROs) to maximize resources and improve timeliness at the national level. Accelerated activities will focus on the additional work that needs to be accomplished in FY 2014 to make a significant impact on achieving the Agency Priority Goal of eliminating the disability claims backlog by processing all claims within 125 days at 98-percent accuracy. The delivery schedule is compressed and incorporates automation that enables claims processors to expedite high priority claims, as well as reduce decision points when deciding which claims to work. Providing these additional resources in FY 2014 will allow for the same scope of work to be accomplished in less time.

2. **Veterans Relationship Management (VRM): Customer Relationship Management (CRM) Unified Desktop; Fix the Phones Enhancements; and Deployed Functionality Improvement - $9.0 Million**

Increased funding of $9.0 million will enable telephone call agents to appropriately respond to and resolve requests in a more timely and effective manner. Continued enhancement of CRM will decrease Veterans' call wait times and allow VA to respond more promptly to their concerns. CRM provides a powerful tool that increases our ability to provide accurate, consistent, and prompt service to our Veterans. This project will:

- Enhance the call flows responding to requests for the status of claims, status of appeals, changes of address, direct deposit, and payment information. This will increase the efficiency and reduce the call times for these high volume calls.

- Update the status-of-claim information to be consistent with the information that is provided by the eBenefits and Stakeholders Enterprise Portal (SEP) portals to ensure that VA is providing a consistent answer to status-of-claim questions across all channels.

- Provide secure messaging capabilities to allow inquiries from the eBenefits, MyHeatheVet, and SEP portals and from public VA Web sites to be routed to and addressed by the appropriate point of contact across VA lines of business.

- Empower the business to support changes in business needs, processes, and rules such as changes reports, letters, and call center scripts without the need for additional development resources.

- Provide the ability for call center agents to schedule appointments in Veterans Health Information Systems and Technology Architecture (VistA) via a CRM interface.

- Allow access to VA's authoritative system of records, the Master Veteran Index (MVI), via the Enterprise Technology Architecture (ETA).

- Provide call center agents a single sign on/log on capability across multiple VistA platforms.

3. Veterans Relationship Management (VRM): Disability Exam Assessment Program (DEAP) - $7.4 Million

Increased funding of $7.4 million will enhance and improve DEAP, which delivers a centralized, Web-based, VA enterprise-wide clinical disability exam and assessment work flow management system. Currently, the production of medical evidence for disability adjudication is handled in 132 instances of VistA, resulting in a fractured system with difficult communication; no automated notification system of request or exam status; and highly variable business practices. DEAP universally assists compensation and pension (C&P) health care professionals in conducting quality, timely, and complete medical evaluations and returning that evidence to Veterans Benefits Administration (VBA) claims adjudicators. It facilitates submission of more accurate exam requests, streamlines inter-departmental and inter-agency (including VA-to-vendor) communication, monitors workload, and tracks performance metrics that will be used for training programs to further increase efficiency, productivity, and accuracy.

4. Other Development - Registries Work - $6.1 Million

Increased funding of $6.1 million is for funding multiple registry projects. Registries provide the database and tools that allow more effective and efficient evidence-based care by allowing Veterans Health Administration (VHA) providers to understand the breadth and depth of occurrence of various conditions or to maintain records of exposure, implants, or procedures supporting the Veteran. Registries support comprehensive follow-up evaluations and tracking of ongoing care for the Veteran. All registry work will be accomplished within the Converged Registry Platform, allowing future registry work to leverage data extent in the converged database.

The following are examples of registries work that will be supported through additional funds:

- Converged Registry Development;
- Clinical Case Registry (CCR);
- Defense and Veterans Eye Injury Registry;
- Traumatic Brain Injury Registry;
- Breast Cancer Registry Defect Repairs; and
- Open Burn Pit Registry.

5. Other Development - Data Access Services (DAS) – $3.0 Million

Increased funding of $3.0 million is required to continue development to provide thousands of data sharing transactions and storage between many high-priority VA programs, and will support efforts such as:

- Computable data for disability benefit questionnaires (DBQ) that are the required source between Compensation and Pension Record Interchange and VBMS Rating Calculators;

- The transaction connection with the Department of Defense for service treatment records (STR), which is vital for VBMS processing; and

- Data flow for DEAP, Integrated Disability Evaluation System and many other medical and benefit systems/applications.

6. Other Projects ($2.0 Million or less each) - $12.0 Million Total

a. Access to Healthcare - Emergency Department Integration Software (EDIS) - $1.6 Million

Increased funding of $1.6 million will support VHA's Emergency Medicine Improvement (EMI) Initiative, which seeks to mitigate the risk of adverse events and to improve delivery of care in VHA Emergency

Departments/Urgent Care Clinics (ED/UCC) by adopting practice standards accepted by the Emergency Medicine professional societies; standardizing the care delivery process in VHA EDs/UCCs; and identifying prospectively the facilities at higher risk of preventable adverse outcomes. EDIS is a key tool to meet this objective. The purpose of this project is to complete development and deployment of EDIS V2 based on business requirements that will transform the system from a "patient tracker" to a "patient workflow management" platform.

b. Access to Health care - Veterans Implant Tracking Alert System (VITAS) - $1.0 Million

Increased funding of $1.0 million will support development of a standardized, electronic documentation process of the key elements for surgically implanted medical devices and populate a national implant registry. This registry will have the ability to identify and locate patients quickly in the event of a recall and serve clinical needs at the point of care. Secondary business drivers are to provide a registry for evaluating functional outcomes for classes of surgical implants and a ready resource for responding to inquiries from other Government agencies (Food and Drug Administration, Government Accountability Office, Office of the Inspector General, etc.).

c. New Models of Care – Health Risk Assessment - $1.2 Million

Increased funding of $1.2 million will support enhancements to the Health Risk Assessment (HRA) Web-based tool to be accessed by Veterans through MyHealtheVet. The Veteran provides health information, receives a health assessment, and an individualized action plan for improved health. New functionality will include satisfaction of clinical reminders with Human Resources Administration (HRA) responses; additional clinical reporting and graphics; referral of Veterans in VHA programs of interest; supporting mobile device usage; and re-hosting in a cloud environment consistent with MyHealtheVet.

d. Integrated Operating Model (IOC) - Human Resources Information System (HRIS) Shared Service Center (SSC) - $2.2 Million

Increased funding of $2.2 million for HRIS will fund implementation of the security controls specified in National Institute of Standards and Technology (NIST) Special Publication 800-53. Revision 4 for a Federal Information Security Management Act (FISMA) High system. The HRIS SSC solution will replace the legacy Personnel Accounting and Integrated Data (PAID) system, which is approaching its end of life and soon will not be sustainable. The new HR solution will facilitate personnel action processing, benefits management, and compensation management. VA needs to establish network connectivity between the HRIS SSC and VA users. The proposed solution will use a

"Trusted Internet Connection" (TIC) and dedicated Multiprotocol Label Switching (MPLS) circuit, implemented as an internal Business Partner Extranet (BPE), which will provide a dedicated "pipeline" between VA and HRIS SSC. This will ensure fully secure data transmission of Personally Identifiable Information (PII) and allow network analysis to increase speed and reliability.

e. Other Development - Safety and Security, Personal Identity Verification (PIV) Application Enhancement - $1.4 Million

Increased funding of $1.4 million is needed to correct a misclassification of PIV DME work. The funds are in the FY 2014 budget as operations and maintenance. A review of the work requested for this project determined that the funds should be properly classified as DME.

f. Other Development - VA Medication Reconciliation: Patient Centered Medication Information Management - $1.0 Million

Increased funding of $1.0 million will fund IT tools to allow VHA clinicians to reconcile medications in line with VHA Directive 2011-012: Medication Reconciliation; Joint Commission National Patient Safety Goal 3.06 for 2011; and the Department of Health and Human Services' Meaningful Use Stages 1, 2, and 3, and VA's Essential Medication Information Standards Directive. This also aligns with the recent Task Force established by the Under Secretary of Health to improve discharge planning. Current tools within VHA do not allow for the ability to completely reconcile medications and communicate the reconciliation with patients, their care givers, and their non-VA providers. The current MedRecon Interim Solution as released fell short of meeting Joint Commission regulations, failing to meet 5 of the 8 core requirements specified.

g. Other Development - Class III to Class I Testing - $1.2 Million

Increased funding of $1.2 million will fund testing and evaluation of additional Class III software for consideration of elevating to Class I status. Class III software is field developed and utilized to support daily medical and business activities. Products were defined in the field and built at often lower costs than could be done by other sources. Testing and accreditation provides the opportunity to elevate quality field developed applications enhancing medical capabilities for all facilities nationally. This program provides oversight to advance field-developed products to become national IT solutions. Many of these Class III capabilities would be excellent choices to be used nationally for the improvement of health care.

h. Other Development - Clinical Flow Sheet - Clinical Observations (CLIO) v2 - $1.0 Million

Increased funding of $1.0 million will enhance Clinical Flow Sheet-CLIO v1 which displays longitudinal clinical data for the overall management of the Veteran's medical care. The Clinical Flow Sheet - CLIO v2 project will provide an interactive clinical flow sheet that will enhance documentation of patient care in clinical settings by adding:

- Branching logic and auto calculations for templates and assessments that will allow for tracking and trending data over time;
- Integration of data elements into the Computerized Patient Record System (CPRS) allowing a comprehensive display of data;
- Interface with medical monitoring devices using Health Level Seven (HL7)
- Standardized reports;
- Interoperability of the terminology; and
- Improved display of data in flow sheet views.

This application will contribute to achieving the goals of meaningful use of electronic health record technology by improving the quality, safety, and efficiency of patient care through improved care coordination.

i. Remaining Projects with Minimal Funding Changes - $1.4 Million

Net funding of $1.4 million is provided for two projects with changes under $1.0 million, including IOC-VA Time and Attendance System (VATAS) and Other Development - TeleCounseling.

7. Project Reductions - $4.2 Million

Within the DME subaccount, the reprogramming among programs and projects reflects the reduced funding for the following:

- **Virtual Lifetime Electronic Record:** Funding is reduced by $3.0 million because of changed requirements and project scope in the Memorial program.

- **Health Management Platform:** Funding is reduced by $1.2 million because two contract awards were less than originally planned.

Operations and Maintenance Subaccount - $43.3 Million

Funding is reduced by $43.3 million. Funds are available for reprogramming in the operations and maintenance subaccount because the Office of Information and

Enclosure 1

Technology realized cost avoidances in the competitive pricing and expenditures on various contracts and agreements.

Department of Veterans Affairs
Fiscal Year 2014 Office of Information and Technology Systems
FY 2014 Reprogramming
(Dollars in Thousands)

	FY 2013/2014 Baseline Plan	Reprogram-Net Total	FY 2013/2014 Revised Plan	FY 2014/2015 Baseline Plan	Reprogram Net Total	FY 2014/2015 Revised Plan	Original 13/14 & 14/15 Total Annual Execution Plan	Revised 13/14 & 14/15 Total Annual Execution Plan	Delta
Total Budget Authority									
Development									
Access to Healthcare	$ 125	$ -	$ 125	$ 3,645	$ 2,639	$ 6,284	$ 3,770	$ 6,409	$ 2,639
Surgical Quality and Workflow Management	$ 1,757	$ -	$ 1,757	$ -	$ -	$ -	$ 1,757	$ 1,757	$ -
Healthcare Efficiency IT Development	$ 1,662	$ -	$ 1,662	$ -	$ -	$ -	$ 1,662	$ 1,662	$ -
Electronic Health Record Interoperability/VLER Health	$ 40	$ -	$ 40	$ 32,882	$ -	$ 32,882	$ 32,922	$ 32,922	$ -
VistA Evolution	$ 29,000	$ -	$ 29,000	$ 219,000	$ -	$ 219,000	$ 248,000	$ 248,000	$ -
New Models of Care	$ 18	$ -	$ 18	$ 32,647	$ 1,156	$ 33,803	$ 32,665	$ 33,821	$ 1,156
Veterans Benefits Management Systems (VBMS)	$ 63,001	$ -	$ 63,001	$ 32,834	$ 10,000	$ 42,834	$ 95,835	$ 105,835	$ 10,000
Virtual Lifetime Electronic Record (VLER)	$ 1,096	$ -	$ 1,096	$ 11,352	$ (3,000)	$ 8,352	$ 12,448	$ 9,448	$ (3,000)
Veterans Relationship Management (VRM)	$ 171	$ -	$ 171	$ 120,157	$ 16,396	$ 136,553	$ 120,328	$ 136,724	$ 16,396
Health Management Platform	$ 11	$ -	$ 11	$ 7,774	$ (1,200)	$ 6,574	$ 7,785	$ 6,585	$ (1,200)
International Classification of Diseases (ICD-10)	$ 29	$ -	$ 29	$ 4,600	$ -	$ 4,600	$ 4,629	$ 4,629	$ -
VHA Research IT Support Development	$ 5,529	$ -	$ 5,529	$ -	$ -	$ -	$ 5,529	$ 5,529	$ -
Integrated Operating Model	$ 1,015	$ -	$ 1,015	$ -	$ 3,040	$ 3,040	$ 1,015	$ 4,055	$ 3,040
Other IT Systems Development	$ 18,670	$ -	$ 18,670	$ 30,400	$ 14,248	$ 44,648	$ 49,070	$ 63,318	$ 14,248
Subtotal	$ 122,124	$ -	$ 122,124	$ 495,291	$ 43,279	$ 538,570	$ 617,415	$ 660,693	$ 43,279
Sustainment O&M									
Medical Operations and Maintenance	$ 2,004	$ -	$ 2,004	$ 863,973	$ (19,569)	$ 844,404	$ 865,977	$ 846,408	$ (19,569)
Benefits Operations and Maintenance	$ -	$ -	$ -	$ 322,301	$ (19,270)	$ 303,031	$ 322,301	$ 303,031	$ (19,270)
Enterprise Operations and Maintenance	$ -	$ -	$ -	$ 810,660	$ (4,440)	$ 806,220	$ 810,660	$ 806,220	$ (4,440)
Interagency Operations and Maintenance	$ -	$ -	$ -	$ 184,720	$ -	$ 184,720	$ 184,720	$ 184,720	$ -
Subtotal	$ 2,004	$ -	$ 2,004	$ 2,181,653	$ (43,279)	$ 2,138,374	$ 2,183,657	$ 2,140,378	$ (43,279)
Development	$ 122,124	$ -	$ 122,124	$ 495,291	$ 43,279	$ 538,570	$ 617,415	$ 660,693	$ 43,279
Sustainment/O&M	$ 2,004	$ -	$ 2,004	$ 2,181,653	$ (43,279)	$ 2,138,374	$ 2,183,657	$ 2,140,378	$ (43,279)
Staffing and Administration	$ 13,156	$ -	$ 13,156	$ 1,026,400	$ -	$ 1,026,400	$ 1,039,556	$ 1,039,556	$ -
H1N1 Supplemental (P.L. 111-32)	$ 2	$ -	$ 2	$ -	$ -	$ -	$ 2	$ 2	$ -
OEF/OIF Supplemental (P.L. 110-28)	$ 2,528	$ -	$ 2,528	$ -	$ -	$ -	$ 2,528	$ 2,528	$ -
Total	$ 139,814	$ -	$ 139,814	$ 3,703,344	$ -	$ 3,703,344	$ 3,843,158	$ 3,843,158	$ -

Question 35. VA has requested $1.828 billion to maintain the current IT infrastructure. Of that, $376.2 million is for IT support contracts. This is approximately a $106 million increase from fiscal year 2015. Please provide the Committee with a breakdown of current and expected support contracts' vendors and costs.

VA Response, VA is making significant investments to improve IT infrastructure to support the new IT capabilities developed over the past 5 years. While the budget for IT Support Contracts increases in FY 2016, it is worth noting that the Department continues to strive for providing the most effective and efficient support of its infrastructure used to move data around the country as is possible. The Department also continues its efforts to improve transparency and accuracy in the classification of funds used to support the IT infrastructure of VA. In developing its 2016 budget, VA also sought to improve accuracy and transparency—some items in FY 2015 were IT support contracts, but were not correctly classified as such. In developing the FY 2016 budget, IT infrastructure contracts are properly classified, with the effect that other lines in the IT infrastructure category showed decreases between FY 2015 and 2016. The IT Support contracts that will be supported by the $376.2 million request in FY 2016 are expected to require obligations on the same order in FY 2015.

The list of contracts for FY 2015 is below. This list is divided into two parts. The first part identifies six large contract items for $112 million. The second list documents some 289 small contracts, most of which are on the order of a few hundred thousand dollars each—the total of these is just over $264 million. The vendors that would address these contracts in FY 2016 will be determined through competitive processes consistent with Federal Acquisition Regulations.

Large Contracts	Planned Total	Contracts Required
CRISP Surge	$12,106,232	1
Help Desk	$52,984,797	2
PAID to the new HRIS SSC	$11,350,356	1
Testing Service Support	$23,689,992	1
VBMS	$12,000,000	1
Total	$112,131,377	6

Other IT Support	Planned Total	Contracts Required
Electronic Health Record Interoperability	$13,913,082	8
Health Administrative Systems—INTER	$759,456	1
Health Administrative Systems—MED	$5,794,924	12
Health Provider Systems/Access to Care	$568,542	2
Human Resources Information System (HRIS)	$9,224,688	9
IT Support Contracts—BENE	$22,162,653	18
IT Support Contracts—ENT	$16,565,356	14
IT Support Contracts—MED	$88,204,720	128
Memorials Development	$2,000,000	7
New Models of Health care	$17,123,453	12
Veterans Benefits Management System (VBMS)	$38,151,800	20
Veterans Relationship Management (VRM)	$49,732,864	58
Total	$264,201,539	289

Question 36. GAO recently outlined how Federal IT investments have historically been plagued by failures and cost overruns resulting in billions of dollars of taxpayer money wasted. Specifically, GAO cited VA's Financial and Logistics Integrated Technology Enterprise program and VA's Scheduling Replacement project as examples of waste. Please detail what specific steps VA has taken to incorporate GAO's recommendations for successful IT management.

Response. In order to address systemic IT project delivery challenges, VA established the Project Management Accountability System (PMAS) in June 2009. PMAS establishes a discipline which ensures the customer, IT project team, vendors, and all stakeholders invested in an IT project focus on a single compelling mission—achieving on-time project delivery. PMAS facilitates relationships which ensure cus-

tomer needs are met, minimizes waste in IT investments and reduces project management and technical risks. Additionally, PMAS rebalances IT requirements with available staffing, focuses IT efforts by funding only projects with adequate resources, and enables VA to intervene in projects as soon as problems arise. In other words, under PMAS, VA can easily determine that if VA IT projects are going to fail, they will fail early and fail fast, allowing VA to more immediately correct or close IT projects which are not succeeding.

PMAS also allows VA to actively address the nine critical factors highlighted by GAO in GAO–15–290 "High Risk Series: An Update." As shown in the following table, VA's Information Technology (IT) management methodology directly addresses the nine critical factors identified by GAO to support the objective of improving the management of large-scale IT acquisitions across the Federal Government:

VA's Implementation of GAO's Nine Critical Factors

GAO's Nine Critical Factors	VA's Implementation Steps
(1) Program officials actively engaging with stakeholders	• VA delivers IT capabilities through its Integrated Project Team (IPTs); IPTs include the project staff, the business sponsors and stakeholders working together and sharing responsibility for delivering IT capabilities on time • Senior leaders review the work of the IPTs at all Milestone Reviews, which are gateways for continued development • In VA, our term for program officials is ''senior leaders''. Senior leaders constantly interact with stakeholders, which are a part of our project teams and business sponsors • Senior leaders also engage with stakeholders when projects experience risk that could prevent an on time delivery; project managers and senior leaders meet weekly to mitigate risk to get a project or increment back on schedule
(2) Program staff having necessary knowledge and skills	• VA ensures all IT Project Managers have completed the Federal Acquisition Corp Project/Program Management (FAC P/PM) certification course and also provide them with opportunities and support to earn their requisite annual continuing learning education credits. • In VA, senior leaders review the composition of all IPTs and do not approve the project to proceed unless the IPT and project team are staffed with individuals that have the necessary knowledge and skills to deliver the agreed to IT capability on time • VA's Office of Information & Technology (OI&T) provides a resource management process that enables project teams to request staff members with the requisite knowledge, skills and experience to make the IPT successful
(3) Senior department and agency executives supporting the programs	• VA's Chief Information Officer (CIO) and all Deputy Chief Information Officers (DCIOs) invest significant time each week to ensuring its IT management framework is being fully and completely executed • Weekly, senior leaders review and approve projects which believe they are ready for the next phase of development • Weekly, senior leaders also support the risk mitigation process by participating in and providing the intervention/resolution requested to reduce risk • VA CIO reviews the progress of execution weekly and monthly and authorizes changes to the policy and process as needed
(4) End users and stakeholders involved in the development of requirements	• The business sponsor/customer creates and approves a Business Requirements Document before starting IT development • Milestone Review Board will not approve a project to move forward without a signed BRD • Stakeholders, business sponsors and any designated end users are all members of the IPT • Milestone Review Board will not approve a project to move forward without an effective IPT
(5) End users participating in testing of system functionality prior to end user acceptance testing	• Business sponsors and end users participate in reviews of code prior to also participating in User Acceptance Testing (UAT), which is an essential part of VA's process for delivering IT capabilities • The Agile methodology, which is embedded in VA's IT delivery approach, requires—and VA enforces-near continual participation of end users and business sponsors as part of the sprint delivery process

VA's Implementation of GAO's Nine Critical Factors

GAO's Nine Critical Factors	VA's Implementation Steps
(6) Government and contractor staff being stable and consistent	• VA has re-structured the method by which it staffs projects. VA uses a competency model to ensure timely, efficient and consistent staffing of all projects. • Projects are not allowed to start or continue work if they do not have all required staff assigned to a project • VA also requires all projects to have stable, consistent staffing of all IPTs • Milestone Reviews review the composition of all IPTs and inquire as to whether the project manager is having any issues with IPT staff composition • Project managers can seek immediate help for any loss of resources via the risk mitigation process • OIT's staffs projects via a resource management board to ensure the fair and consistent assignment of staff to projects
(7) Program staff prioritizing requirements	• VA's IT delivery framework requires the IPT members to work together to develop an agreed set of requirements; establishing the priorities for these requirements is an essential element of this process and for creating and approving the BRD • IPTs constantly review their agreed set of requirements and ensure over time that priorities remain correct • Use of the Agile framework also enforces the consistent prioritization and re-prioritization (as necessary) of requirements
(8) Program officials maintaining regular communication with the prime contractor	• IPTs are the organizational entity for ensuring program officials have regular communications with the prime contractor; representatives of the prime contractor attend IPT meetings and are responsive to the project manager to provide contractual deliverables • At a minimum IPTs meetings are held bi-weekly; but most are held weekly
(9) Programs receiving sufficient funding	• No project can start or continue work unless it has sufficient funding for success • If funding is lost mid-development, the project is paused until a determination can be made to either restore funding or cease work • No project is expected to be successful and make on-time deliveries if funding is not sufficient

The preceding table defines the steps that VA has taken to incorporate GAO's recommendations for successful IT management.

By following these steps, over the past five years (FY 2010—March, FY 2015), VA has achieved an on-time delivery rate of 83% (through the end of March 2015), and an overall delivery rate of 92%. As noted in GAO–14–361 Report "Information Technology: Agencies Need to Establish and Implement Incremental Development Policies" released on May 8, 2014, GAO reviewed five agencies' incremental development approaches. Of the agencies surveyed, VA was the only Federal agency to meet all three evaluation factors, which were delivery of functionality every 6 months, well-defined functionality, and defining a process for enforcing compliance.

Response to Posthearing Questions Submitted by Hon. Richard Blumenthal to U.S. Department of Veterans Affairs

HEALTH CARE

Non-VA Care

Question 37. What tangible steps has VA taken to ensure coordination of non-VA care options, particularly in conjunction with the new Choice Program that to date has seen low utilization?

Response. The Chief Business Office Purchased Care (CBOPC) will continue bi-weekly calls with VA Medical Center staff and the Choice/Patient-Centered Community Care Third Party Administrators (TPAs) that address usage, utilization strategies, and communicating newly implemented work flow processes associated with both programs. CBOPC has increased the frequency of direct communications and onsite visits with VA medical centers (VAMCs) that have low utilization of Choice and PC3. In addition, CBOPC is communicating with VAMC Directors to keep them

informed of PC3/Choice provider network efforts, cost benefits, and barriers to current utilization.

Public Law 114–41, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, included amendments to the original Veterans Choice Program as well as instruction for VA to review the statutory authorities VA has for purchasing Veteran healthcare in the community and to recommend a plan to consolidate these programs into a single program to be known as the "Veterans Choice Program." With this initiative VA assigned a special team of subject matter experts to develop the plan for submission to VA leadership, OMB and ultimately Congress. The outcome of this work is expected to provide a more streamlined authority for VA to purchase any care in the community.

Question 38. What level of funding included in the President's budget request would be used to ensure VA is adequately communicating with veterans and providers about the availability of non-VA care options and how they work? How are veterans who don't meet the eligibility criteria for the Choice Program informed of other fee-basis care options?

Response. At this time, how much of the President's budget is used to communicate with Veterans and providers regarding non-VA medical care is unknown. However, CBOPC ensures that communication is available to providers and Veterans. One avenue of such communication is the CBOPC Web site, http://www.va.gov/PURCHASEDCARE. The CBOPC Web site provides information for non-VA medical care providers on the submission of claims and other pertinent information for their offices and also contains many references for Veterans, including how to request non-VA medical care. Additionally, VA facilities have pamphlets and brochures that also describe non-VA medical care options.

Veterans who do not meet the Choice eligibility requirements may be referred for non-VA medical care if the care needed is not available at the VA facility. Once a Veteran has been referred for non-VA medical care, the local Non-VA Care Coordination Office (NVCC) will make contact and work with the Veteran to identify a non-VA provider. Once the non-VA provider has been identified, the local NVCC office will coordinate with Veteran and the non-VA medical provider to schedule an appointment for the needed medical care. The NVCC office will continue to coordinate with the non-VA medical care provider and the Veteran for any additional needed medical care, whether through the non-VA provider or the VA facility.

Question 39. Given the intense spotlight placed on exceptionally long-wait-times thousands of veterans faced across the country last year, what is VA doing to ensure local VHA staff are better informed about how and when to use non-VA care?

Response. A Choice intranet site has been developed that includes training material and a resource toolkit for VA employees. The resource toolkit includes recorded training sessions, fact sheets, Frequently Asked Questions (FAQs), and information for Veterans, Veteran Service Organizations, and the Public. Additionally, each VA health care facility has designated Choice Champions to provide VA staff and Veterans with information and guidance on the Choice Program. To support the Choice Champions, a Pulse Web site was created to provide a forum for discussing questions and issues relating to Choice Program implementation; a monthly call has been established (starting in April 2015, it will be bi-weekly); and a Choice Champions email group was developed to also address outstanding issues and to disseminate timely information.

In addition, Veterans Health Administration (VHA) staff can find information about the use of non-VA medical care on the CBOPC's National Non-VA Medical Care Program Office (NNPO) intranet site. Included on that site are policies, procedures, training, memorandums, fact sheets, handbooks, directives, and access to a Question and Answer (Q&A) database. Also located on the NNPO intranet site are copies of the bi-weekly publication, The Bulletin, which contains articles specifically for non-VA medical care staff at VHA health care facilities. Moreover, NNPO conducts monthly calls with non-VA medical care staff and also provides visits to VA health care facilities to support Non-VA Medical Care Managers and Business Operations through process improvement plans, training, data analysis, and communication tools.

Finally, a Patient-Centered Community Care (PC3) intranet site is available for VHA staff that includes presentations, training, fact sheets, and reference guides. Bi-weekly meetings are held with designated VHA staff aimed toward education and promoting the use of PC3.

Formularies

Question 40. For soldiers transitioning from active duty, continuity of health care, particularly as it relates to treatments for mental health conditions can be extremely important. The VHA Directive issued on January 20, 2015, indicates that

VA providers are not to discontinue mental health medications based solely on "differences between the VA and DOD drug formularies, VA Criteria-for-Use, or the cost of the drug."

a. Does VA have the necessary resources to implement this directive by the March 13, 2015, and to provide appropriate oversight to make sure that clinicians are conforming to the policy?

Response. Yes, VA has the necessary resources. The Directive describes longstanding VHA practices which have been in place since approximately 2006, so in essence the Directive is already implemented. VHA recently conducted an in depth analysis of its practices to continue mental health and pain medications in Servicemembers transitioning from DOD to the VA healthcare system. This review found very few exceptions where the practice that is now policy was not being followed (21 exceptions of 2,000 Servicemembers evaluated). VA plans to periodically repeat the analysis to ensure that the Directive is being followed.

b. Does VA anticipate significant increased expenses due to paying for these treatments which may be more expensive than what the clinician would prescribe for a veteran who is outside of the transition period?

Response. For the specific population impacted by the Directive (i.e., Servicemembers transitioning their care from DOD to VA who are receiving mental health medications from DOD) VA does not expect significant increases because our practice has been to continue those medications when clinically safe and appropriate. VA would only anticipate large increases in expenses if this policy were expanded to other drug classes and to all VA beneficiaries (i.e., not just transitioning Servicemembers who are receiving mental health medications from DOD).

Accountability

Question 41. If VA were given the authority to make a change to the Title 38 Appointment and Compensation System for Medical Center and Network directors, how does the Department intend to ensure these individuals are meeting VHA's performance goals?

Response. The Department of Veterans Affairs (VA) intends to ensure Medical Center Directors and Network Directors meet Veterans Health Administration's performance goals through the existing performance management process. A Title 38 appointment for senior executives will not change the current Performance Management System. VHA's current Title 38 executives are held to the same performance standards as members of the Senior Executive Service (SES).

The Deputy Under Secretary for Health for Operations and Management conducts quarterly reviews with Network Directors to evaluate their performance and the performance of their organizations against desired outcomes consistent with the senior executives' performance plans. These reviews include assessment of leadership's capacity to promote and support effective governance, integrity, and high reliability. Other focus areas include: Quality Improvement, Patient Safety, Environment of Care, Veteran Experience, Customer Service and Workforce Training/Readiness.

VHA conducts a comprehensive performance review annually of each senior executive, including SES and Title 38 SES Equivalents, in accordance with VA Handbook 5027 and the VA SES and Title 38 SES-Equivalent Performance Management Systems policy. VHA complies with law and Department policy related to executive performance evaluation. The SES or SES Equivalent prepares an assessment, which documents their accomplishments throughout the performance year; the supervisor provides an evaluation, and the Reviewing Official conducts a second level review to rate the executive's performance. VHA's Performance Review Committee reviews all VHA evaluations and makes rating recommendations to the VA Performance Review Board (PRB). The PRB reviews all VA SES and SES Equivalent performance appraisals and makes rating recommendations to the Secretary, who has final decision authority of the rating of record.

Question 42. Why has VA not set out more ambitious projections for itself in the strategic framework outlined by VHA's National Leadership Council, especially as it relates to satisfaction measures of veterans?

Response. The Department of Veterans Affairs (VA) is implementing an historic department-wide transformation, changing VA's culture and making the Veteran the center of everything we do. Transformation must start with organizational reforms to better unify the Department's efforts on behalf of Veterans. These reforms, which will take time, center on the ICARE values. These reforms include the Department's "MyVA" initiative, which reorients VA around Veteran needs and empowers employees to assist them in delivering excellent customer service to improve the Veteran experience. VHA's Blueprint for Excellence is aligned with the Department's Strategic Plan and supports the "MyVA" initiative. The Blueprint lays out themes and supporting strategies for the transformation to improve the performance

of VA health care now and offers a common framework for action with VHA's Strategic Plan. The overarching principle is our focus on the Veteran experience.

While VA is in a process of transformation, VHA is in the process of developing performance measures and targets for 1) Veteran experiences of Access to routine, urgent, and specialist care; 2) self-management support; and 3) overall rating of their inpatient and outpatient care and their VA provider. To achieve a high level of performance, much work has to be done over a sustained period of time to ensure we hire the right numbers of staff, build the right networks of community-based providers, train our staff using the correct core values and skills, and ensure the supporting infrastructure that guarantees a high degree of reliability. Furthermore, how Veterans rate their experience will also depend on the trust they place in us. We recognize that rebuilding that trust takes time and we are committed to providing high quality, proactive, personalized patient-drive care to Veterans and strive to improve our services.

Antibiotic Resistance

Question 43. In January 2014, VA issued a Directive requiring VA medical facilities to implement antimicrobial stewardship programs. Addressing the urgent, growing problem of antimicrobial resistance will require both the development of new antibiotic products and the stewardship of existing products. VA facilities, as well as private sector facilities, must implement meaningful stewardship programs to do their part in avoiding unnecessary and very difficult to treat infections.

a. What is the current status of the VA directive on antimicrobial stewardship programs, and are there any plans to share data and lessons learned from stewardship programs among facilities and with other stakeholders?

Response. The Antimicrobial Stewardship Programs Directive (VHA Directive 1031) requires all VHA facilities to implement, maintain and evaluate an Antimicrobial Stewardship Program. A national field survey has been developed to determine compliance with Directive 1031 and is awaiting final approval from 10N for dissemination. Data and resources are shared through educational webinars and made available on a VHA SharePoint site for use by antimicrobial stewardship champions in the field.

b. Does VA have resources available to address any changes that may be necessary within facilities based on what is learned from stewardship programs?

Response. This initiative has no designated funding and relies on a core group of highly productive field volunteers, the National Antimicrobial Stewardship Taskforce. There is no fenced facility-specific funding for stewardship; such funding would fall under the facility's general medical resources as part of patient care.

Women Veterans

Question 44. As more and more women are becoming veterans, it becomes even more important that VA provides gender-specific services such as obstetrical and gynecology specialty care. However it is also important that VA services generally available are appropriate for women. For instance, primary care, cardiology and mental health options must be equally available to women as they are to men. How will the funding in the President's budget request ensure that all appropriate services available within VHA are accessible to women and that primary care providers are counseling women veterans about risks specific to women such as potential risk of birth defects associated with prescribed medication?

Response. To provide the highest quality of care to women Veterans, VA offers women Veterans assignments to trained and experienced Designated Women's Health Providers (DWHP) who can provide general primary care and gender-specific primary care in the context of a longitudinal patient/provider relationship. Today, DWHPs are available at 95 percent of VA medical centers (VAMC), and 84 percent of community-based outpatient clinics in comparison to 2009 when women's health providers were at only 33 percent of VAMCs. VA plan is that whenever a woman Veteran enters the health care system, she will have access to a DWHP. To meet this plan, VA must ensure that all new primary care hires are proficient in the care of women as well as men. VA is continuing to train and update skills of current VA primary care and emergency providers in the care of women. Since 2008, VA has provided intensive training to over 2,000 women's health providers and provided over 50 different online, accredited women's health classes, which can be taken 24/7 to enhance the flexibility of learning opportunities for employees. The combination of educational offerings provides not only basic training in women's health but advance courses so that providers and other staff can keep their skills and knowledge up-to-date.

VA is raising awareness of cardiovascular risk in women Veterans through collaboration with the American Heart Association's Go Red for Women Movement.

VA's national Women's Veterans Cardiovascular Work Group, published the State of Cardiovascular Health in Women Veterans Report and in February, 2015 encouraged all sites to develop specific cardiovascular risk reduction programs for women through a national Go Red Challenge.

VA is raising awareness of preconception care for women Veterans and VA providers by expanded training in preconception care to providers serving high risk women and developing the Preconception Care mobile application for providers as a tool to enhance and support the integration of preconception care into primary care. By addressing health and wellness before pregnancy, preconception care is an essential component of well women care during the childbearing years.

VA has developed a national curriculum for primary care and mental health providers addressing topics including the effects of pregnancy and menopause on women's mental health and the effects of psychiatric medications on reproductive health. Additionally, VA has developed a national pharmacy order check that alerts providers of potentially teratogenic medications through the computerized electronic medical record. Later this year, a national Information Technology project, the Notification of Teratogenic Drugs Project, will launch that will enhance the current computerized order check. This will provide enhanced electronic record functionality for providers to improve patient safety when prescribing high risk medications to women of reproductive age.

Question 45. Military Sexual Trauma (MST) has gained increased recognition over recent years. VA estimates that of veterans receiving VA health care, approximately one in four women and one in a hundred men report experiences of MST during their military service. How much does VA anticipate spending on treatment associated with MST? Please describe how this funding would be utilized to adequately train all appropriate staff, including schedulers and support staff on sensitivity related to MST.

Response. VA's data on the prevalence of MST comes from its universal screening program, which includes all Veterans seen for any VA health care. It is important to note that not all Veterans who disclose MST during screening need or are seeking MST-related treatment, as many recover from their experiences without professional care. Of those Veterans who are experiencing difficulties, their presenting problems include a wide range of both mental and physical health conditions. As such, the types and costs of MST-related care will vary based on the specific health conditions for which Veterans decide to seek treatment. The treatment provider makes the determination whether a particular episode of care is MST-related for a particular Veteran; this is indicated on a case-by-case basis in a Veteran's medical record. Therefore the cost of providing MST-related care is incorporated into broader health care costs for each VA healthcare system; it is not feasible to treat MST as a separate line item.

In FY 2014 VA reviewed Veteran utilization and cost data for treatment episodes judged to be MST-related between FY 2009 and FY 2013, in order to estimate the total costs of VA outpatient and inpatient care provided in those years. Projections for future costs in years FY 2014-FY 2016 were also made based on utilization in past years. These cost estimates (which include treatment for both female and male Veterans) are provided in the table below.

Military Sexual Trauma Related Care

Year	Number of Male and Female Veterans Receiving VA MST-Related Care	Obligations
FY 2009	65,264	$207,599,000
FY 2010	72,548	$256,193,000
FY 2011	80,688	$283,563,000
FY 2012	88,990	$308,156,000
FY 2013	96,807	$319,363,000
FY 2014*	104,760	$346,913,000
FY 2015*	112,814	$368,637,000
FY 2016*	120,816	$389,527,000

* Years FY 2014 through FY 2016 are based on projections of future costs and therefore may be different than actual costs incurred in those years.

MST-related education and training for VA staff MST training initiatives occur at both the local and national level. At a local level, every VA health care system has a designated MST Coordinator who serves as a contact person for MST-related

issues and can help Veterans access VA services and programs. MST Coordinators help ensure that local staff members receive mandated MST education and training, and provide training as needed in clinics throughout the health care system to ensure that staff members have the needed knowledge and skills to work effectively with MST survivors. For example, MST Coordinators host Grand Rounds and other educational presentations, distribute informational materials, and provide clinical consultation. These training duties are collateral to being full-time clinicians, so their salary support comes from their primary role within their local VA health care system.

Nationally, all VA mental health and primary care providers are required to complete mandatory training on MST. Mental health providers complete a web-based training on MST that provides a comprehensive review of issues relevant to provision of mental health care to MST survivors. Primary care providers must complete a web-based training that reviews a range of issues including health conditions associated with MST, screening sensitively for MST, how MST can affect a Veteran's experience of healthcare, how to appropriately adapt care to address the needs of MST survivors, and VA documentation requirements.

VA's national Mental Health Services program office funds a national MST Support Team which is, in part, charged with coordinating and expanding national MST-related training initiatives. For example, the team hosts monthly continuing education calls on MST-related topics that are open to all VA staff and available online afterwards. Since 2007, the MST Support Team has hosted an annual training focused on MST-related program development as well as the provision of clinical care to Veterans who experienced MST. The MST Resource Homepage is a VA intranet community of practice Web site where VA staff can access MST-related resources and materials, review data on MST screening and treatment, and participate in MST-related discussion forums. In addition, all VA staff have access to an online independent study course on MST and other Web-based training materials.

The MST Support Team has also partnered with VA rollouts of empirically-supported treatments for PTSD, depression, and anxiety to include MST-specific information. These national initiatives train therapists in evidence-based practices such as Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), Acceptance & Commitment Therapy (ACT), and Cognitive Behavioral Therapy (CBT). Conditions targeted by these treatments are strongly associated with MST, meaning these national initiatives have been an important means of expanding MST survivors' access to cutting-edge treatments.

The MST Support Team also conducts an ongoing National Review of the Accessibility of MST Coordinators. This program is an innovative "secret shopper" initiative to survey the experiences a Veteran would be likely to have in attempting to reach an MST Coordinator via telephone. This initiative was expanded in FY 2014 in order to help maintain improvements and continue progress toward the goal of ensuring Veterans are able to reach the MST Coordinator at every health care system. The latest round of this review is currently underway. In conjunction with the review, MST Coordinators are encouraged to provide training to frontline staff, such as clerks and telephone operators, on how to appropriately and sensitively assist MST survivors. The MST Support Team has developed handouts and tips sheets to support MST Coordinators in these efforts.

Also, in conjunction with Sexual Assault Awareness Month (April) 2015, the MST Support Team is releasing a new MST sensitivity training video titled, "You can make a difference: Honoring Veterans who experienced MST." To underscore the importance of being sensitive to the needs of MST survivors, Secretary McDonald provides an introduction to the video; Veteran Ruth Moore also appears in the video to share her perspectives on how every VA staff member can assist Veterans who experienced MST. The video and associated training materials are applicable to all VA staff but particularly designed to target frontline staff. MST Coordinators will use the video in awareness-raising events during Sexual Assault Awareness Month, as well as in ongoing efforts related to the National Review of the Accessibility of MST Coordinators and training of frontline and support staff more generally.

BENEFIT PROGRAMS

Disability Compensation Claims System

Question 46. Provide the methodology utilized to allocate personnel and resources to the regional offices and specifically address any refinements made to this methodology in the past fiscal year. In discussing refinements made over the past fiscal year, please specifically address VBA's Office of Strategic Planning efforts to design a workforce capacity model.

Response. Please see the attached VBA Workforce Analysis submitted to Congress on March 2, 2015.

DEPARTMENT OF VETERANS AFFAIRS (VA)
REPORT TO CONGRESS ON CLAIMS PROCESSING

Report Language: Claims Processing - The recommendation includes an additional $30,000,000 for the General Operating Expenses, Veterans Benefits Administration account. These additional resources are to be utilized to hire additional claims and support personnel at Regional Offices. The Committee believes that the effort to eliminate the backlog through a number of initiatives, including mandatory overtime, has highlighted the need for additional personnel at Regional Offices. The Committee recommendation also directs VBA, working in conjunction with the Office of Policy and Planning, to conduct a workforce analysis by Regional Office and to undertake a detailed review of VBA's Resources Allocation Model. The analysis should be developed in the framework of a multi-year, strategic assessment that should include a plan for how to measure and incorporate the increasing number of claimed conditions and complexity of claims into the systematic approach VA utilizes to distribute resources to the Regional Offices. VA shall also report on how the National Work Queue will be integrated with the Resource Allocation Model. The Department is directed to provide this analysis to the Committees on Appropriations of both Houses of Congress no later than February 2, 2015. The Committee continues to believe that quality cannot be sacrificed in the pursuit of eliminating the claims backlog. As such, the Department must continue the efforts of the Quality Review Teams [QRT] in assessing the performance of claims processing operations and bridging the gap between local and national standards. It is critical that QRTs perform follow-up spot audits in Regional Offices that have undergone challenge training to ensure that quality standards are being met. Additionally, VA must ensure that all training programs for claims processors are routinely followed up with testing and monitoring at regular intervals. *Senate Appropriations Report 113-174, pgs. 65-66.*

Discussion:
The additional $30 million for the General Operating Expenses (GOE), Veterans Benefits Administration account will be used to hire an additional 250 full-time equivalent (FTE) employees to support claims processing in FY 2015.

Current Resource Allocation Methodology:
VBA's Resource Allocation Model (RAM) is a systematic approach to distributing field resources each fiscal year. The RAM utilizes a weighted model to assign compensation and pension FTE resources based on regional office (RO) workload, including rating inventory; and rating, non-rating, and appeal receipts. Starting in FY 2014, the RAM incorporated additional variables to more closely align with VBA's transformation to a paperless, electronic environment, where receipts can be assigned and managed at the national level. These variables include station efficiency (claims completed per FTE), quality, and RO capacity. VBA leaders use the model as a guide, making adjustments for special circumstances or missions performed by individual ROs. Special missions include: Appeals Management Center (AMC), Benefits Delivery at Discharge (BDD) sites, Integrated Disability Evaluation System (IDES) processing sites, Quick Start processing locations, National Call Centers (NCCs), foreign claims processing

locations, radiation processing locations, Camp Lejeune Contaminated Water (CLCW) processing locations, and Pension Management Centers (PMCs).

VBA's Capacity Model for Workload Distribution (operational):
VBA's Office of Field Operations will undertake two major capacity analyses:

- Classification system for claim types – based on combination of complexity factors that cluster claims around average processing time (i.e., age of the claim, issue type, era in which the injury occurred, number of issues)
- Standard Average Minute Framework – utilizes VBMS transactional data to determine actual processing time to complete claims

The results of such analyses will be used to enhance our overall workload management strategies and NWQ capabilities. The goal is to create a standard processing time around the different claim complexity types which can be used to enhance overall resource allocation and more accurately determine capacity.

VBA's Capacity Model for Predictive Analytics (future target setting):
VBA's Office of Strategic Planning is using transactional data to design a workforce capacity model that will analyze production capacity and the time required to process claims. Studies include the following components:

- Baseline time and motion study – Baseline assessment of production capacity based on the observation of claim processing activities collected over a period of time.
- Transactional Data Collection – Utilizes VBMS transactional data to determine actual processing time to complete claims.

After transactional data is analyzed, an assessment of the capacity to support the rating of different types of compensation claims will be conducted. The model will provide the following:

- Variation in rating time and total claim processing time across ROs;
- Potential production gains from specialization;
- Simulation of the optimal production capacity from staff allocation; and
- Assessment of other phases of the claims cycle following the validation of the rating phase.

Workforce Analysis:
A workforce analysis is the foundation of any good workforce plan as it directly aligns the organization's needs with outcomes. The workforce analysis will involve three distinct phases: (1) data gathering of VBA's current resources and performance; (2) input of VBA's future performance requirements and organizational structure (which is designed to meet Veteran customer service expectations); and (3) the acknowledgement and analysis of the gap that exists between the first two phases. The workforce analysis is an ongoing effort, and as new data becomes available (such as the VBMS transactional-level data and NWQ post-implementation data), it will be incorporated in VBA's plan to gain efficiencies.

With the exploration and analysis of future workload management functionality, VBA will continue to evaluate the studies and prioritize the integration of enhancements in the

NWQ. The lessons learned from the NWQ and the findings from the workforce capacity model studies will be utilized to improve overall VBA resource allocation, target projection setting, and overall operational efficiency.

The timeline to incorporate these changes is provided below:

- FY15 - focus on eliminating the backlog and implementing NWQ
- FY16 - gather and evaluate VBMS transactional data by RO (i.e., incorporate the increasing number of claimed conditions and complexity of claims into the systematic approach VA utilizes to distribute resources)
- FY17 - adopt a single capacity model, modify VBA's RAM, and conduct a workforce analysis that will be used for future resource decisions and projections

VBA will be working in coordination with VA's Office of Policy and Planning (OPP) on the workforce analysis and review of VBA's RAM methodology.

National Work Queue (NWQ):
This paperless workload management initiative is designed to improve VBA's overall production capacity and accuracy. The initial phase of NWQ is currently underway with VBA's four Area Directors monitoring inventory levels and redistributing workload across ROs. With over 94 percent of VBA's pending claims inventory now in the electronic processing system known as the Veterans Benefits Management System (VBMS), VBA can efficiently manage workload to improve and normalize processing timeliness at the national level. NWQ also helps VBA ensure efficient use of overtime resources across ROs.

NWQ is scheduled for deployment in FY15. The roll-out of NWQ will be in phases, with eight ROs entering for an initial 30-day period (preliminary period), followed by full national deployment. The Directors of these ROs will also act as Change Champions in providing critical feedback and input regarding NWQ. The phased roll-out strategy is designed to test both system functionality as well as end-user experience within the NWQ environment.

The NWQ preliminary roll-out will incorporate the following in the allocation of workload:

- Employee Performance Standards for Claims Processors – Total number of employees by position type, plus a multiplier (used to ensure the target and actual station capacity are accounted for).
- Special Mission Distinctions – Resources for ROs supporting multiple missions are separated into distinct groups.
- Veterans Service Center (VSC) Team Distinctions – Resources for ROs are separated into teams, to include: Rating, Non-Rating, Appeals, Intake Processing Center (IPC), Public Contact, Congressional, and Temporary Special Assignment. Phase 1 rollout of the NWQ will address the distribution of rating cases only. Future phases will incorporate all other workload.
- Staff Assignment – Special Mission and VSC Team Distinctions are based on actual on-board staff availability as of the most recent pay-period data.
- Availability – Controlled and unanticipated factors that impact production include overtime, leave, training, 2nd level review, special projects, and union time.

The RO in the state where the Veteran resides will continue to be the first filter for determining where the claim will be assigned as long as that RO has the capacity to provide the Veteran with a timely decision.

Future NWQ rollout upgrades will be based on VBA's Capacity Model analysis outcomes. Data obtained from these two initiatives will be used to update VBA's RAM.

Quality Review Teams:
All ROs have a Quality Review Team (QRT) comprised of dedicated Quality Review Specialists (QRSs) whose sole purpose is to improve the quality of claims processing. QRSs ensure individual employee reviews are performed on a monthly basis; communicate station and individual employee error trends to RO leadership; and assist in the identification of individual employee and station training needs.

The following initiatives will assist in bridging the gap between local (RO level) and national quality.

- Data gathered from NWQ implementation will be utilized to implement standardized in-process quality review procedures
- A performance standards work group has been tasked with revising performance standards for Veterans Service Representatives (VSRs) and Rating Veterans Service Representatives (RVSRs) and is reviewing other governmental and private-sector performance standards that will help to drive a more Veteran-centric measures and outcomes
- A monthly report card is completed for each Challenge training participant, which is used to identify error trends and track performance
- National consistency studies are required for all VSRs, RVSRs and QRSs and are conducted quarterly. Noted error trends are used to develop national refresher training for claims processors.
- VBA developed and validated skill certification tests for positions in the VSCs and PMCs. Skill certification tests are currently in place for VSRs, RVSRs, Decision Review Officers (DROs) and Supervisory VSRs (SVSRs). All journey-level employees, for whom a skill certification test is applicable, are now required to take the test for their position.

As VBA transitions into a national work environment, it becomes even more critical that quality review and trend analysis become consistent and streamlined across all QRTs. Quality will always be at the forefront of workforce analysis.

Veterans Benefits Administration

February 2015

Question 47. In 2009, VA began an effort to update the VA Schedule for Rating Disabilities.

a. Provide an itemized list of funding expended in FY 2015 on the rating schedule modernization.

Response. For FY 2015, VBA budgeted $3.1 million to update the VA Schedule for Rating Disabilities (VASRD), including $956,000 for pay and benefits, $30,000 for travel, $2.0 million for an earnings loss study, $46,000 for rent; and $54,000 for supplies and other services.

b. Provide an itemized list of the requested funding in FY 2016 for the rating schedule modernization. Also, include the number of FTE assigned to or supporting this modernization effort.

Response. For FY 2016, VBA requests $3.1 million to update VASRD, including $960,000 for pay and benefits, $30,000 for travel, $2.0 million for an earnings loss study, $46,000 for rent, and $54,000 for supplies and other services. Five employees are currently assigned to support the VASRD modernization effort.

c. Provide the Project Management Plan, the VASRD Update Operating Plan and project schedule for the rating schedule modernization.

Response. Please see the attached Project Management Plan. VBA does not have a VASRD Operating Plan. Table 2 in the Project Management Plan shows the stages of concurrence for each body system. Since the Plan was last updated, proposed rulemakings for several systems have been published. VA understands the importance of updating the Rating Schedule and will ensure the completion of updates as each system proceeds through concurrence.

VASRD PROJECT MANAGEMENT PLAN
October 27, 2014

Updated December 15, 2015

I Plan Overview/Charter/Business Need

In 2003, GAO designated VA's disability program as high risk due, in part, to challenges faced in keeping criteria for evaluating disability and determining compensation consistent with advances in medicine, technology, and changes in the labor market and society. In addition, two recent earning loss studies--CNA's *Final Report for the Veterans' Disability Benefits Commission: Compensation, Survey Results, and Selected Topics* published in 2007; and Economic Systems Inc.'s *A Study of Compensation Payments for Service-Connected Disabilities*, published in 2008—have focused on VA's disability compensation program and noted a need to modernize the VA Schedule for Rating Disabilities (VASRD).

As a result, in 2009 the Veterans Benefits Administration (VBA) Under Secretary for Benefits (USB), on behalf of the Secretary for Veterans Affairs (VA), directed the revision and update of the 15 body systems that are contained in the VA Schedule for Rating Disabilities (VASRD), 38 C.F.R. § 4, under the authority of 38 U.S.C. § 1155.

VBA has completed and revised this plan in response to GAO's report entitled "VA Disability Compensation: Actions Needed to Address Hurdles Facing Program Modernization (2012)." Although not clearly documented in the operating procedures, the intent of the plan is, that at the termination of each VASRD system review, to subsequently enter into a 5-year cycle of staggered reviews (see Table 2). This systematic approach to avoid letting body systems become outdated by 10 years or more. This strategy is based on recommendations from a 2007 report from the Institute of Medicine (IOM) entitled "A 21st Century System for Evaluating Veterans for Disability Benefits," which proposes a series of corrections to the existing schedule for rating disabilities and guidance for improving Veterans benefits in the 21st century.

The update of these regulations will apply current medical science and econometric earnings loss data to the VASRD. This will provide VA with a more accurate rating system and ensure that Veterans with service connected diseases or injuries are compensated based on modern standards.

The VBA Compensation Service is charged with developing and implementing the PMP to revise the VASRD. This plan includes the implementation of updates to the Compensation Service examination templates and worksheets, as well as

the organizational policy, training, manual and computer system changes that are required when final regulations are published in the Federal Register.

II Project Scope

Each of the 15 VASRD body systems will be updated and revised using current medical science and econometric earnings loss data. For most body systems, the initial revision will focus on updating the VASRD medically by: (1) updating the medical terminology; (2) adding medical conditions not currently in the VASRD; and (3) refining evaluation criteria based on medical advances that have occurred since the last revision and the current understanding of functional changes associated with or resulting from disease or injury (pathophysiology). For some body systems, including those have gone the longest without update, the initial revisions will consider econometric earnings loss data where feasible.

VA examination worksheets and templates associated with the new regulations will be updated prior to its publication in the Federal Register. In this regard, Disability Benefits Questionnaire (DBQ) examination sheets will be appropriately modified for each body system to allow a smooth transition and continuity of operations of the claims evaluation process.

Changes to VBA policy, procedural, manual, training, and system changes will be initiated during the regulation concurrence process. Each of the impacted Compensation Service Staffs will be notified in advance of the final publication of the regulation. The Staffs will execute a unique implementation strategy for each VASRD regulation system update depending on the nature of the change, the anticipated impact and VBA organizational priorities.

III VASRD Body System Reviews

The review of each VASRD body system occurs in three phases. The Working Group researches and analyzes each body system. During the Development Phase, regulation writers draft the working groups' recommended changes into proposed regulations. In the Concurrence Phase, subject matter experts (SMEs) and leadership review each proposed regulation for publication in the Federal Register.

Working Group Phase

VASRD conference forums were held to initiate the review of each of the 15 body systems. During these conferences, working groups were formed to support the ongoing review process. The groups were comprised of Veterans Health Administration (VHA) and non-VHA clinicians, SMEs, rating veterans service representatives, quality review specialists, and attorneys. Once established, these

volunteers participated in the working group's weekly or biweekly teleconference sessions. Veterans Service Organization (VSO) representatives were subsequently added to the working groups in 2012. In general, each group has approximately 4-20 members. Working group members participate in weekly or biweekly teleconference sessions with occasional in-person meetings.

During the early Working Group phase, all the diagnostic codes for each VASRD body system are evaluated for relevance, accuracy, obsolescence, medical significance, applicable medical/scientific advances, and levels of severity reflective of disability. Each of these parameters is thoroughly assessed by all members of the group.

The Working Group phase generally lasts 4-9 months depending on the extent and complexity of the VASRD system.

Development Phase

The development of a proposed regulation has two distinct stages of progression:

Drafting Stage - At the end of the Working Group Phase, VBA drafts the required justification to document the recommended changes to the VASRD. This documentation is required in the drafting of the preamble when comparing the current and proposed regulations. It provides the foundation, based on medical literature; practice patterns or parameters; standards of patient management or care; or advances in the understanding of a body system, which support the changes.

Peer Review Stage - At the conclusion of the drafting stage, the proposed regulation undergoes several peer reviews. First, the regulation has to meet the approval of the chairman and members of its respective body system working group. Once that approval is received, VA Medical Officers, regulation writers, attorneys, claims processing experts, and other SMEs work together to review and fine-tune the proposed regulation. Upon completing all appropriate revisions, the regulation is submitted for concurrence.

Concurrence Phase

The proposed regulation for each body system is comprehensively assessed for its medical, legal, and economic impact. It must be approved at each level of the concurrence process before it can proceed to the next.

After the proposed regulation is approved by Compensation Service leadership, it is then submitted for concurrence outside Compensation Service. The regulation requires VBA Office of Disability Assistance, Chief of Staff and USB

concurrence. At VA, the Office of General Counsel (OGC) and Veterans Health Administration (VHA) must approve the regulation as well. During this period of time, the Compensation Service Contract Management and Budget Staff works independently with VBA resources to develop an impact analysis of the proposed regulation. Once the regulation receives approval from OGC and VHA and is signed by the Secretary of VA, it is submitted to the Office of Management and Budget (OMB) for official review. OMB considers the financial impact of the proposed regulation, based on the VBA impact analysis. If OMB concurs with it, the proposed regulation is sent to the Federal Register for initial publication. The proposed regulation is available for public comment for 60 days. After the 60 day period is complete, the regulation is returned to Compensation Service to address all the comments and to make any necessary revisions. The draft of the final regulation then progresses through the entire concurrence process again before it is published in the Federal Register and goes into effect.

IV Risks

Every effort will be made to proactively identify risks ahead of time from the project's onset. Risks will also be comprehensively assessed by VBA during the evaluation of each VASRD body system impact analysis. If significant risks are identified, mitigation strategies will be implemented to minimize the potential impact. The potential risks are expected to fall into four general categories:

- Negative impact on the VA benefit claims backlog,
- Impact on IT resources for required modifications
- Exorbitant costs associated with newly proposed benefits,
- Public or organizational dissatisfaction with the nature or extent of the regulation changes, and
- Public or organizational dissatisfaction with the timeframe in which the regulation changes can be implemented.

V Resources

VBMS enhancements will incorporate any VASRD changes. Identified funding requirements will be presented to leadership for budget formulation. Previous funding requests have considered VASRD updates in accounting for VBMS project requirements. VBMS will continue to be enhanced and additional system capabilities will be released in future generations of VBMS that will be deployed over the next few years. Any anticipated costs upon publication of final rules will be subject to any changes that occur throughout the public comment period. Assuming all recommended changes in the proposed rules, any associated with changes to IT systems will be minimal, at most. An exact cost for these changes cannot be provided at this time.

In addition, current and previous budget requests have considered staffing levels and resources needed for updates to policies, procedures, communications, training, and manual updates related to the VASRD update project. Therefore, VA does not anticipate any additional funding requests for these resources related to the VASRD update project.

Estimated mandatory costs or savings will be addressed by the impact analysis accompanying each proposed and final rule.

VI Milestone Tables

The tables on pages 7 and 8 of this document provide the current status for each of the 15 VASRD body system reviews and the plan for entering into a 5-year cycle of staggered reviews.

Table 1: Status of VASRD Body Systems. This table describes the current status of each body system. Please note that there are now 14 body systems, as respiratory and ENT have been merged into one system.

Table 2: Projected 5 Year VASRD Review Cycle. This table shows the estimated initiation dates for the next round of VASRD reviews for each body system regulation. Going forward, all VASRD reviews and regulation updates are to be completed within 5 years of the last publication.

VII Lessons Learned

The Mental Disorders; Endocrine; Hematologic and Lymphatic; Genitourinary; Dental and Oral; and Digestive body systems were presented to VSO representatives during a public Summit held in June 2012. The purpose of this Summit was to familiarize the representatives with the proposed regulations for these systems, since the VSOs were not part of the Working Group process up to that point in the project.

Based on feedback from working group participants and required update considerations, the following body system reviews resumed the Working Group Phase in 2013: Musculoskeletal and Mental Disorders. Both systems have moved to the drafting and concurrence phase in 2014.

VIII GAO Milestones

Based on recommendations of the Government Accountability Office (GAO) Report to Congressional Committees of September 2012, VA has implemented the following modifications to the PMP:

- VBA is developing associated policies, procedures, communications, training, impact analyses, system changes, and manual updates in conjunction with the proposed regulations to ensure a smooth and timely implementation.

- VBA is conducting a comprehensive impact analysis for each of the proposed regulations for the 15 VASRD body systems. These analyses should indicate the potential for an increased number of claims and increased costs associated with the publication of each regulation. VBA will plan and evolve its implementation strategy accordingly.

- VBA is exploring options to conduct adequate and well-controlled scientific studies to obtain the necessary earnings loss data applicable to the VASRD for future updates. VBA has determined that existing earnings loss studies are sufficient for initial revisions to the VASRD, at no additional cost.

- While VBA decides the best option to obtain current earnings loss data, participants of the body system working groups will continue to work using evidence-based, empiric, and clinical data to complete the new generation of rating schedules.

- VBA is incorporating information derived from experience, market research, conferences, forums, and collaboration with each of the VASRD body system working groups into the PMP.

Table 1: Status of VASRD Body Systems

System	Conditions	Proposed Rule Status
Hematologic Lymphatic	Blood elements	VBA Internal Concurrence
Endocrine	Hormone related	Proposed Rule published July 2015. Drafting Final Rule
Dental and Oral	Mouth, teeth, jaws	Proposed Rule published July 2015. Drafting Final Rule
Genitourinary	Urinary tract, kidney, ureter, etc.	VBA Internal Concurrence
Digestive	Internal organs, intestine, liver, etc.	VBA Internal Concurrence
Cardiovascular	Heart, blood vessels	VBA Internal Concurrence
Infectious Diseases	Infections – vector transmissible	VBA Internal Concurrence
Respiratory/ENT	Lungs and respiratory; Sinus disease, ear infections, pharynx; Audiology	VBA Internal Concurrence
Gynecological and Breast	Reproductive disorders	Proposed Rule published February 2015. Final Rule undergoing VBA concurrence
Skin	Rashes, burns, etc.	VA Internal Concurrence
Neurological	Neurological conditions and seizures	VBA Internal Concurrence
Eye	Eye diseases	Proposed Rule published June 2015. Drafting Final Rule
Mental Disorders	Psychiatric and psychological disorders	VBA Internal Concurrence
Musculoskeletal and Rheumatology	Disorders of muscles, joints, bones and ligaments	VBA Internal Concurrence

Table 2: Projected 5 Year VASRD Review Cycle

VASRD Body System	Estimated Initiation Date of Next Review
Hematologic and Lymphatic	Within one year of date final rule is published
Endocrine	Within one year of date final rule is published
Dental and Oral	Within one year of date final rule is published
Genitourinary	Within one year of date final rule is published
Respiratory/ENT	Within one year of date final rule is published
Digestive	Within one year of date final rule is published
Cardiovascular	Within one year of date final rule is published
Infectious Diseases	Within one year of date final rule is published
Eye	Within one year of date final rule is published
Respiratory	Within one year of date final rule is published
Skin	Within one year of date final rule is published
Neurological and Convulsive	Within one year of date final rule is published
Gynecological and Breast	Within one year of date final rule is published
Mental Disorders	Within one year of date final rule is published
Musculoskeletal and Rheumatology	Within one year of date final rule is published

VASRD Regulations Status 12-10-2015

BODY SYSTEM	CURRENT STATUS	FEDERAL REGISTER PUBLICATION PROJECTION
Gynecological & Breast	• Proposed rule published in FR Feb 27, 2015 • Public comment period ended April 29, 2015 • Final rule in VBA concurrence	Final rule - 2016
Dental & Oral	• Proposed rule published in FR July 28, 2015 • Public comment period ended September 28, 2015; addressing comments and drafting final rule	Final rule - 2016
Hemic & Lymphatic	• Proposed rule published in FR August 6, 2015 • Public comment period ended October 5, 2015; addressing comments	Final rule - 2017
Eye	• Proposed rule published in FR June 9, 2015 • Public comment period ended August 10, 2015; addressing comments and drafting final rule	Final rule - 2017
Endocrine	• Proposed rule published in FR July 9, 2015 • Public comment period ended September 8, 2015; addressing comments and drafting final rule	Final rule - 2017
Skin	• Proposed rule in VBA concurrence	Proposed rule - 2016
Mental Disorders	• Proposed rule in VBA concurrence	Proposed rule - 2017
Digestive	• Proposed rule in VBA concurrence	Proposed rule - 2017
Neurological & Convulsive	• Proposed rule in VBA concurrence	Proposed rule - 2017
Infectious Diseases	• Proposed rule in VBA concurrence	Proposed rule - 2017
Cardiovascular	• Proposed rule in VBA concurrence	Proposed rule - 2017
Genitourinary	• Proposed rule in VBA concurrence	Proposed rule - 2017
ENT & Respiratory	• Proposed rule in VBA concurrence	Proposed rule - 2017
Musculoskeletal	• Proposed rule in VBA concurrence	Proposed rule - 2017

d. Does the FY 2016 request include any funding to support updates that will need to be made to IT solutions, including VBMS, disability benefit questionnaires, rules-based calculators, or other initiatives based on the current VASRD? How much funding does VA anticipate these updates will require upon publication of final rules for the various body systems?

Response. Yes, the FY 2016 request includes funding to support updates that will need to be made to IT solutions, including VBMS, related to the VASRD modernization project. This funding is included in OIT's budget request for sustainment of IT systems.

Question 48. Provide the number of FTE assigned to or supporting VA's accreditation program. Also, provide the following information for calendar years 2014.

Response. The Office of the General Counsel's (OGC) accreditation program currently has six full-time employees (two permanent GS–7 employees, two temporary GS–7 employees, one permanent GS–8 employee, and one permanent GS–11 employee) assigned to the accreditation program as well as three-fourths of a Deputy Chief Counsel position (formerly titled as Deputy Assistant General Counsel) and approximately one-tenth of a Chief Counsel position (formerly titled Assistant General Counsel). In calendar year 2014, the program had three full-time employees (one GS–7, one GS–8, and one GS–11 (from June 2014 to December 2014)) assigned to the accreditation program as well as approximately one-third of a GS–15 Deputy Assistant General Counsel position and approximately one-tenth of an Assistant General Counsel position. In addition, the Veterans Benefits Administration detailed one employee to the program for the entire calendar year of 2014, and temporarily detailed approximately eight other employees, for periods lasting at least one month, to the program to assist with the backlog of accreditation applications in calendar year 2014. VA has also utilized legal externs working with OGC to assist with the program.

a. The number of individuals per year who have sought recognition to represent individuals before VA broken down by representatives of service organizations, attorneys or agents.

Response. VA's accreditation matters are tracked within OGC's recordkeeping database, GCLAWS. The GCLAWS database is primarily a recordkeeping and case-tracking database for legal matters, and is somewhat limited in its ability to track certain types of information for VA's accreditation program in a way that permits reliable targeted searches of statistical programmatic data for that program. For example, this database tracks accreditations and suspensions/cancelations, but does not specifically track other data, such as the number of accreditation applications received per year, the number of applications denied, or the number of applications withdrawn or abandoned. From the information available, we are able to estimate the number of applications received per year from the number of accreditation applications granted per year. With respect to attorneys and service organization representatives, the number of applications granted closely approximates the number of applications received, because very few applications are denied in these categories, for reasons discussed in paragraph (c) below. Accordingly, the estimates provided below are based on the number of attorney and service organization representative applications granted in calendar year 2014. Additionally, we have estimated the number of agent applications based on the number of cases attributable to the one VA employee who was assigned exclusively to agent applications for calendar year 2014.

Accreditation Applications Received in Calendar Year

Calendar Year	VSO Representatives	Attorneys	Claim Agents	Total
2014	~3,150	~1,940	~680	>5,000

b. Of those requests for recognition, how many were granted and how many were denied?

Response. In FY 2014, VA granted accreditation to 1,940 attorneys, 47 agents, and 3,150 service organization representatives.

Regarding the number of service organization representatives accredited, we note that a service organization representative may be accredited with more than one organization. This figure represents the number of service organization representative accreditations granted, not the number of individuals accredited.

Regarding the number of agent applications, as explained in greater detail in response to question (c), the processing of an application for accreditation as an agent has several additional steps compared to processing of an application for accredita-

tion as a service organization representative or attorney. Some of these steps were implemented at the beginning of calendar year 2014 in response to the Government Accountability Office's (GAO) observations in its 2013 report VA Benefits: Improvements Needed to Ensure Claimants Receive Appropriate Representation. Specifically, GAO noted that VA's then-existent process for accrediting agents relied on (1) applicants to self-report background information without independent verification, and (2) character references that did not provide relevant information. By the beginning of calendar year 2014, VA had modified its process for accrediting agents to incorporate background checks and direct questions to the applicants when potential areas of concern are identified regarding the applicant's criminal or employment history as well as the applicant's motivation for seeking accreditation by VA. In some cases agent applicants withdraw or abandon their applications because they realize that they initially applied for VA accreditation for some purpose other than to represent veterans on their VA benefit claims. In other cases the additional steps yield valuable information that informs OGC's accreditation decision. VA does not currently track the number of applications that are denied in comparison to the number of applications that are closed because they are withdrawn or abandoned. In addition, because the accreditation process for agents takes more than a year, some of the applications received in calendar year 2014 are still pending.

c. On average, how long does it take VA to process a request for recognition?

Response. Applications for accreditation as a service organization representative are generally processed in less than 60 days, applications for accreditation as an attorney are processed in 60–120 days, and applications for accreditation as an agent take over one year to process to completion. Agent applications take considerably longer to process because there are several additional steps, such as the frequent need to obtain additional information or clarification from the applicant, conducting a background check, checking character references, and scheduling schedule and reviewing the agent exam. As part of the initial application, the character and fitness qualifications of service organization representatives are attested to by the certifying official of the organization and the character and fitness qualifications of attorneys are presumed based on good standing with the state bar. However, there is not an equivalent vetting process inherent in the application for agents and, therefore, VA must specifically examine the character and fitness and qualifications of each of these applicants.

d. How many individuals had their recognition suspended or canceled?

Response. The following table shows the number of cancelations that occurred in FY 2014. The accreditation database does not track disciplinary history, but rather whether the person is currently accredited. Two of the attorney cancelations were due to action taken by VA in response to a complaint. By regulation, service organizations are permitted to request cancelation of the accreditation of one of their representatives at any time, with or without stating a cause. If the cancelation is due to misconduct or incompetence of the representative, the regulations require the organization to inform VA of the reasons for the cancelation. Three of the cancelations of service organization representatives were for a stated cause. The remainder of the cancelations shown below were either at the request of the individual (such as an attorney or agent retiring) or at the request of the service organization without a stated cause (such as when an accredited veteran service organization representative's employment ends).

Attorneys	126
Agents	4
Service Organization Representatives	1318

e. How many complaints were filed against individuals who are recognized to represent claimants before VA, how many were found to have merit, and how many were referred to the Inspector General, a law enforcement agency, or other similar enforcement entity and how many of the referred cases resulted in further enforcement, disciplinary or legal action?

Response. VA received 47 complaints regarding individuals and organizations assisting individuals with claims for VA benefits. The complaints implicated the activities of approximately 44 accredited individuals and 34 individuals and organizations that are neither accredited recognized nor recognized by VA but are alleged to be assisting individuals with VA benefit claims. Some complaints implicated multiple individuals and organizations.

The majority of these individuals (21 accredited individuals and 23 unaccredited individuals and organizations) were brought to the attention of VA based on their

use of the same marketing materials to market financial products to potential VA pension applicants residing in California. VA referred this matter to the California Attorney General and the California Insurance Commissioner for any action they deemed appropriate under state law.

VA referred two matters involving using the VA logo to market financial products to Veterans to law enforcement. One matter was referred to the California Insurance Commissioner for any action he deemed appropriate under state law and the other was referred to the VA Office of the Inspector General.

In two matters, VA sent cease and desist letters and, based on subsequent information provided to us, determined that no further action was required.

Regarding three matters, VA has been unable to take further action because the complainant has not provided VA with a privacy release authorizing the release of information to the subject of the complaint.

The remaining complaints are pending. In the cases involving accredited individuals, VA is currently gathering additional information and determining whether disciplinary proceedings will be necessary. For cases involving individuals who are not accredited, it is VA's general practice to send a cease and desist letter and, if VA concerns remain unresolved, to refer the matter to appropriate state authorities.

Education Benefits and Implementation of Executive Order 13607

Question 49. I understand that there is a large backlog of complaints pending in the GI Bill Feedback System. Does VA have the necessary resources to respond to all the complaints about educational institutions registered in the GI Bill Feedback System by veteran students? How does VA plan to resolve this backlog? Is VA sharing complaints registered with the GI Bill Feedback System with Federal and state law enforcement agencies when the complaints are received?

Response. The GI Bill Feedback System was implemented in January 2014 without additional FTE or funding resources. Despite this limitation, VA has handled over 2,700 complaints from education beneficiaries and has closed 1,900 complaints. Approximately 850 complaints are currently open and active, including 480 complaints with responses from schools that have not been matched to the original complaints for closure. The remaining 370 complaints are awaiting a response from the school. This is a significant improvement from the 1,100 open and active complaints in January 2015 when additional staff was assigned. VBA expects improvements to continue and will continue to actively monitor workload to determine if additional resources are necessary. VA provides complaints to Federal and state law enforcement agencies through the Federal Trade Commission's Consumer (FTC) Sentinel System.

Question 50. Is VA receiving updates from Federal and state law enforcement on their investigations and legal actions to stop predatory practices against veterans? If VA is receiving such updates, is VA identifying patterns of deception and predatory practices against veterans? How is VA protecting veterans from those practices?

Response. VA is routinely receiving updates from DOD and the Department of Education on their compliance activities and findings, but VBA's Education Service is not receiving updates directly from Federal and state law enforcement with the exception of activities that can be viewed through Consumer Sentinel. VA will suspend and/or withdraw any institution's eligibility for VA education benefits when it is found in violation of any element of the statutory approval requirements, which generally refer to deceptive, erroneous, false and misleading advertising practices. There are no references in the statute to "predatory practices."

Question 51. Executive Order 13607 directs VA to institute uniform procedures for referring potential matters for civil or criminal enforcement to the Department of Justice and other relevant agencies. Has VA implemented these procedures?

Response. Yes, VA has implemented these procedures through the GI Bill Feedback system and its direct connection to FTC's Consumer Sentinel database. Criminal matters are referred to VA's Office of Inspector General.

HOMELESS VETERANS

Question 52. Describe the methodology and criteria utilized to determine whether and where to expand the domiciliary care for homeless veterans program.

Response. The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) methodology for determining where a Domiciliary Care for Homeless Veterans (DCHV) program should be located emphasizes two primary criteria. First, the location should be an urban center with a significant homeless Veteran population. Second, the location should have few, if any, VHA residential treatment programs. As part of the VA Secretary's Transformation 21 (T21) plan to end homelessness among Veterans, VHA identified five urban centers with significant homeless

Veteran populations and no residential treatment programs. These locations included Philadelphia, Atlanta, Miami, Denver and San Diego.

A suitable location to lease in Miami was not found after numerous solicitations and the DCHV was subsequently moved to West Palm Beach, FL as part of a minor construction project. Philadelphia, Atlanta, Denver and San Diego are operational and the West Palm Beach building is under construction.

The need to further expand or reduce DCHV beds may be initiated by a Veterans Integrated Service Network (VISN) based on a regional review of current and projected treatment needs using available projection models. In accordance with VHA policy, VISNs are required to submit a Business Plan that justifies a need to develop or reduce DCHV beds, which must be approved by the Under Secretary for Health (USH). VISN 8 submitted a proposal to develop a 40-bed DCHV in San Juan, PR. This proposal was approved and leased space is currently being solicited.

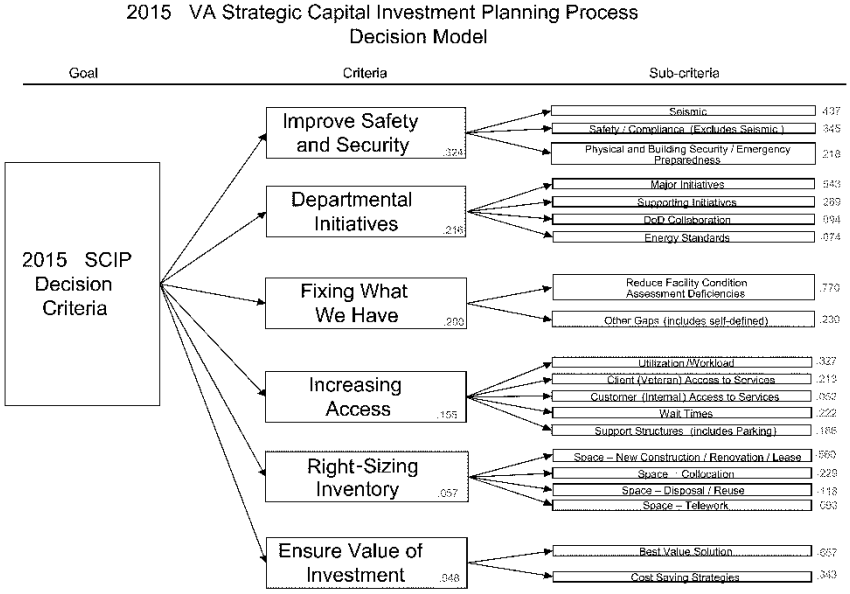
Question 53. Describe how staff in VA's new Homeless Veteran Community Employment Services will interface with staff from the Department of Labor's Homeless Veteran Reintegration Program.

Response. The Homeless Veteran Community Employment Services' (HVCES) community employment coordinators (CEC) work with Department of Veterans Affairs (VA) and non-VA partners to identify local gaps in current competitive employment services and to develop new employment opportunities targeting homeless and formerly homeless Veterans. It is expected that CECs develop collaborative relationships with Department of Labor's Homeless Veteran Reintegration Program staff at all sites where these programs co-exist to prevent duplication of services and improve employment outcomes for Veterans exiting homelessness.

CONSTRUCTION AND LONG RANGE CAPITAL PLAN

Question 54. Provide a list of priority weights for the major criteria and sub-criteria used to inform the FY 2015 Strategic Capital Investment Plan decision plan.

Response:



Question 55. The budget request contains a legislative proposal to allow VA cemeteries to lease air rights above VA cemeteries. Please provide a list of the cemeteries that would be able to lease air rights, along with the total square footage available above each.

Response. Under the proposal, all cemeteries would be allowed to lease air rights. NCA has no intention of encouraging air space usage over cemeteries.

INFORMATION TECHNOLOGY

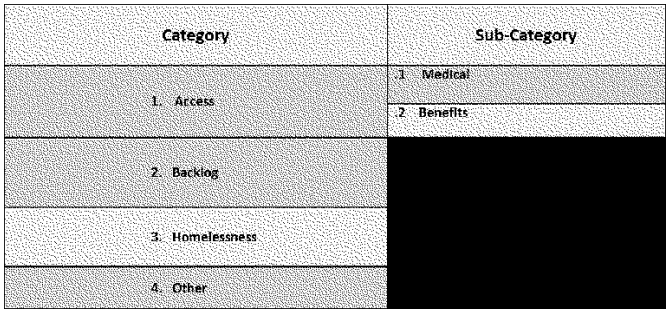
Question 56. Provide a list of criteria utilized to prioritize information technology investments, along with a description of the prioritization process.

Response. All items within the information technology account were put through a two-stage prioritization process. The first stage consisted of prioritization based on a three-dimensional taxonomy. The second stage consisted of prioritization based on further defined categories and how investments supported the Secretary's Agency Priority Goals (APGs). Both stages are characterized below:

Stage 1: Consistent with the Secretary's direction, the taxonomy was focused on three major dimensions: Veteran centered outcomes, direct or indirect benefit to the Veteran, and whether these benefits were quantifiable, qualitative, or neither. Due to the focus on Veteran- centered outcomes, activities categorized as indirect or that were not categorized were not funded. The taxonomy is shown below.

1. Quantified, direct Veteran centered outcome
2. Qualified, direct Veteran centered outcome
3. Direct Veteran centered outcome (asserted, but not quantified, not qualified, nor well described)
4. Quantified, indirect Veteran centered outcome
5. Qualified, indirect Veteran centered outcome
6. Indirect Veteran centered outcome (asserted not quantified, not qualified, nor well described)
7. Not prioritized

Stage 2: Within each of the prioritization criteria above, a further refinement was applied and is shown below in priority order. This priority is based on the Secretary's direction regarding the three current APGs and how an investment supported each.



Question 57. Please provide a copy of timeliness standards and any guidelines associated with veteran notifications of data breaches involving PII or health data.

Response. We are required by the HIPAA Breach Notification Rule to notify Veterans within 60 days of discovery of any breach involving unsecured protected health information, and VA Handbook 6500.2 requires VA to make notification within 30 days from the date the incident occurred for other breaches. We currently average 28 days to make notification.

Question 58. What actions is VA taking to actively recruit additional VLER Health partners to enhance access to clinical data and improve clinical decisionmaking abilities for veterans?

Response. The Department of Veterans Affairs (VA) is actively seeking additional Virtual Lifetime Electronic Record (VLER) Health partners resulting to improve clinical decisionmaking abilities for Veterans. VLER Health leadership understands and believes that pursuing additional VLER Health non-VA partners is vital to improving clinical decisionmaking abilities for Veterans. Our Exchange team has established nearly 40 partners from across the country. Our Direct team is working toward adapting use cases for sharing health data between VA facilities and Veteran State Home federally Qualified Health Centers, long term care facilities, and mental health providers. Our Regional Health Information Exchange team is adopting and publishing a coherent and reproducible Health Information Exchange approach for engaging states, regions, and communities.

When researching potential new partners, every state in the Nation is looked at from a variety of viewpoints and considerations including: (1) Looking for the highest Veteran enrolled states; (2) Reviewing top purchased care sites for VA from across the Nation; (3) Reviewing coverage for VA's Rural Health locations; (4) Com-

paring VAMC recommended list of potential partners; (5) Considering potential partner referrals from HealtheWay and Social Security Administration; (6) Reviewing potential partners that reach out to VA directly; (7) Reaching out to Health Information Service Providers (HISPs) as well as non-VA clinical partners; and (8) Increasing outreach and awareness to non-VA partners via communications.

Bottom line: Adhering to an evaluation process that selects future partners with the greatest likelihood of success by considering: (1) areas of greatest need; (2) Veterans Affairs Medical Center (VAMC) and partner collaboration; and (3) Health Information Exchange (HIE) technical capabilities, is critical to improving Veteran care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN BOOZMAN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 59. Secretary McDonald, private medical providers and hospitals in Arkansas are having a very difficult time receiving reimbursement for providing emergency medical care to veterans. In Arkansas, we have cases that date back to 2012 and for some of our smaller community hospitals, this is a serious financial burden. My office has also received calls from the Louisiana Hospital Association where they are experiencing similar problems and this appears to be problem throughout VISN 16. What can be done to help these hospitals and medical providers close out these claims?

Response. The Veterans Health Administration's (VHA) Chief Business Office (CBO) has been focused on improving the timeliness of claims processing. In December 2014, less than 36 percent of the Veterans Integrated Service Network (VISN) 16 non-Veterans Affairs (VA) medical care claims had been pending for less than 30 days. As of February 2015, that number has improved to 50 percent. Currently, VISN 16 is processing approximately 55 percent of their claims within 30 days, and we expect this number to continue to improve.

On November 12th and 14th, 2014, CBO's Purchased Care (PC) leadership met with members of the Louisiana Hospital Association (LHA) onsite in Louisiana to discuss the recent consolidation, corrective actions, and sustainment plan. Additionally, a focused review of provider high dollar accounts was completed and contact information for ongoing issues was provided. CBO's PC leadership also addressed the backlog of claims, customer service issues, provider remittance reports, and backlog of reconsiderations/appeals.

A Tiger Team visited VISN 16 the week of November 17–21, 2014. This team addressed the claims payment backlog, operational issues, and corrective actions required to improved vendor relations and claims processing timeliness. Since this visit and implementation of a backlog reduction strategy, VISN 16 has continued to process more claims than received and has made ongoing improvements in their overall claims inventory, as described above. In addition, a review of customer service and provider relations was conducted by CBOPC Customer Service Center (CSC) leadership. A plan to consolidate the VISN 16 Customer Support Staff was implemented and this staff is now aligned directly under the CBOPC CSC structure. Continued training and customer service expectations are being provided to staff to further assist with provider and veteran relations.

a. I bring this situation to your attention because I believe it has ramifications that extend well beyond hospitals being reimbursed for emergency medical care. The Choice Act relies upon the private sector to accept and treat veterans and if these hospitals are experiencing this much difficulty getting reimbursed, they may decide that dealing with the VA and treating veterans under the Choice Act is not worth it because of the financial uncertainty that it might entail. Do you share this concern?

Response. The Department of Veterans Affairs (VA) shares this concern. VA contracted with Health Net Federal and TriWest Healthcare Alliance to implement the Choice Program. Health Net Federal and TriWest Healthcare Alliance reimburse the contracted provider within their networks for the services performed under Choice. Health Net Federal and TriWest Healthcare Alliance, in accordance with their contracts, then invoice the VA for services performed by the contracted providers.

Question 60. Dr. Clancy, I am concerned about the projected deficits within the VAMCs. I am being told that within the Fayetteville, AR, VAMC they are projecting a $22M deficit and VISN 16 as a whole is projecting a $220M deficit for this fiscal year. To your knowledge is this accurate?

a. What is the reason that these VAMCs are projecting deficits and what can be done to address these shortfalls? Is this due to VA projecting that the Choice Act

would be used at a higher rate and therefore less funding would be needed for VAMCs because more veterans would be seeking outside care?

Response. As of August 19, 2015, VISN 16 has no projected deficits at any of its VAMCs, including Fayetteville. VHA will continue to work with VISN 16 to ensure that all resource needs are met to prevent unnecessary delays in Veteran care.

Including the funding provided by the Veterans Access, Choice and Accountability Act, VISN 16 has received a funding increase of 7.2 percent in FY 2015. This increase in funding contrasts the 5.8 percent increase realized in the entire VHA FY 2015 budget. The Acting VISN 16 Director is to provide a detailed analysis of why VISN 16 has such a large shortfall in view of the funding increase received this year. VHA intends to report those findings back to the Committee once the data is received and reviewed.

VISN and Medical Center Directors have a very challenging mission balancing funding requirements in light of new patient care practices, advances in medical technology, accounting for non-VA care, and supporting an aging infrastructure. VHA is working closely with VISN leadership to ensure that each VISN has the most appropriate funding based on Veterans' demand for health care in their region.

b. As of now, do you anticipate submitting a reprogramming request to Congress in which you will request transferring money from Choice Act accounts into the medical care account?

Response. With respect to the $5 billion appropriated by section 801 of the Choice Act, VA does not currently anticipate deviating from the spending plan that it previously submitted to Congress.

With respect to the $10 billion appropriated by section 802 of the Choice Act, there is no legal authority that would permit VA to transfer funds from the section 802 Veterans Choice Fund to the medical care appropriations accounts, even with Congressional approval.

c. The FY 2016 budget request for VA in the Medical Care account is $58.662B which is 5.12% above the FY 2015 appropriated amount. Is this increase intended to address these projected deficits within the VAMCs?

Response. Compared to the enacted 2016 advance appropriations level, as requested in the 2015 President's Budget, this year's 2016 request for VA health care services is $1.299 billion higher. This request for additional funding is necessary to ensure the delivery of high-quality and timely health care services to veterans and other eligible beneficiaries. For the first time, VA is requesting an increase above the enacted advance appropriation in all three Medical Care accounts: $1.124 billion in Medical Services, $105 million in Medical Facilities, and $70 million in Medical Support and Compliance.

The total net increase of $1.299 billion is due to the following factors:

- Ongoing health care services estimate increased by $599.9 million, driven largely by estimates of the cost of new Hepatitis C treatments and updated actuarial trends based on the latest actual data.
- A reduction in projected base appropriations health care costs due to enactment of the Veterans Choice Act; VA estimates that $452 million in requirements will shift from the regular program as Veterans who would otherwise receive care in the VA health care system instead choose to participate in the new Veterans Choice Program, as established in the Veterans Choice Act and funded by section 802 of the Act.
- Long-Term Services and Supports estimate has increased by $51.1 million, reflecting trends in the most recent actuals and the continued investment into non-institutional settings.
- Ongoing health service programs not projected by the EHCPM increased by $221.6 million. The Caregivers program cost estimate increased by $249.4 million, driven largely by an increase in the projected number of Caregivers receiving stipend payments. The combined sum of the estimates for CHAMPVA, reimbursement to the Indian Health Service and tribal health programs, caring for eligible Camp Lejeune Veterans and families, and readjustment counseling decreased by $27.8 million based on updated actuals and revised assumptions in workload for Camp Lejeune and Indian Health Service.
- VA programs to end Veterans' homelessness increased by $128 million, for a total of $1.393 billion. The increased estimate allows VA to fully support projected utilization in its homeless programs, including the Supportive Services for Veterans Families (SSVF) program and the Department of Housing and Urban Development-VA Supportive Housing program (HUD-VASH).
- Healthcare Infrastructure Enhancements increased by $666.9 million. Facility activation costs have increased by $468.2 million over the initial advance appropriation estimate of $130 million to $598.2 million; the initial estimate was based on

construction delays that have caused under-execution of activations in recent years. However, VA has made progress in resolving these issues, and as a result has increased confidence that the additional funding will be required in FY 2016. The cost estimate of supporting the Veterans Integrated System Technology Architecture (VISTA) evolution project has been revised downward from $208.3 million to $159.6 million. Estimated non-recurring maintenance obligations grew from $460.6 million to $708.0 million, to address high-priority emerging capital needs as identified through the Strategic Capital Investment Planning (SCIP) process; this increase excludes funding provided by the Veterans Choice Act. See Volume 4, Chapter 7 for additional information on the SCIP process and the NRM program.

- The cost of VHA proposed legislation remains nearly unchanged with an estimated cost decrease of $0.5 million. The 2016 budget includes estimates for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) healthcare benefits for beneficiaries up to age 26.
- Additional budgetary resources decreased by $84.4 million (collections, reimbursements and transfers). The estimate for the Medical Care Collections Fund decreased by $26.3 million. Reimbursements decreased by $51.0 million and transfers to the Joint DOD/VA Medical Facility Demonstration Fund increased by $7.1 million.

Update to the 2016 Advance Appropriations Request
Excludes Veterans Choice Act
(dollars in Thousands)

Description	2016 Advance Approp.	2016 Current Estimate	Increase/ Decrease
Health Care Services	$49,882,074	$50,481,994	$599,920
Veterans Choice Program Cost-Shift		($452,000)	($452,000)
Long-Term Services and Supports:			
Institutional	$5,572,601	$5,526,958	($45,643)
Non-Institutional	$1,836,847	$1,933,555	$96,708
Long-Term Services and Supports [Total]	$7,409,448	$7,460,513	$51,065
Other Health Care Programs:			
CHAMPVA, Spina Bifida, FMP & CWVV	$1,854,870	$1,883,882	$29,012
Caregivers (Title 1)	$305,716	$555,096	$249,380
Indian Health Services (P.L. 111-148)	$38,649	$28,062	($10,587)
Camp Lejeune - Veterans and Family (P.L. 112-154)	$71,906	$19,720	($52,186)
Readjustment Counseling	$237,544	$243,483	$5,939
Other Health Care Programs [Subtotal]	$2,508,685	$2,730,243	$221,558
Ending Veterans Homelessness	$1,265,000	$1,393,000	$128,000
Healthcare Infrastructure Enhancements:			
VISTA Evolution	$208,265	$159,596	($48,669)
Non-Recurring Maintenance	$460,600	$708,000	$247,400
Activations	$130,000	$598,174	$468,174
Healthcare Infrastructure Enhancements [Subtotal]	$798,865	$1,465,770	$666,905
VA Legislative Proposals	$49,914	$49,375	($539)
Obligations [Total]	$61,913,986	$63,128,895	$1,214,909
Funding Availability:			
Appropriation	$58,662,202	$58,662,202	$0
Trns to North Chicago Demo. Fund	($252,073)	($259,145)	($7,072)
Trns to DoD-VA Health Care Sharing Incentive Fund	($15,000)	($15,000)	$0
Medical Care Collections Fund	$3,252,857	$3,226,548	($26,309)
Reimbursements	$266,000	$215,000	($51,000)
Funding Availability [Total]	$61,913,986	$61,829,605	($84,381)
Annual Appropriation Adjustment		$1,299,290	$1,299,290

VISN and Medical Center Directors, many of whom, as you know, are acting, have a very challenging mission balancing funding requirements in light of new patient care practices, advances in medical technology, accounting for non-VA care, and supporting an aging infrastructure. We are working closely with the VISN leadership to ensure that each VISN has the most appropriate funding based on Veterans' demand for health care in their region.

Question 61. Secretary McDonald, within the VA's budget for major and minor construction, this account has the largest increase in terms of percentage: 46.64% increase in the FY 2016 request from what was enacted for FY 2015. How much of this money does the department intend to use to modify facilities so as to better accommodate and care for our female veterans

Response. Based on the Veterans Health Administration's (VHA) preliminary minor construction projects for FY 2016, VHA anticipates providing design or construction funding for projects associated with some form of privacy to accommodate women with total project costs totaling $341 million. These projects include new and/or expanded community living centers, inpatient mental health buildings, emergency departments, outpatient clinics, inpatient units, etc.

Each of VHA's major construction projects, submitted in the FY 2016 budget, support some aspect of women's privacy in the project's overall scope. In the FY 2016 budget request, there is over $508 million of funding for construction projects that include some form of privacy. These projects include the construction or renovation of community living centers, a mental health clinic, an outpatient clinic, and rehabilitation buildings.

The following table represents funding included in the FY 2016 budget request for major construction projects supporting our women Veterans:

Location	FY 2016 Request	$ for Women	Description of Women's Health
Perry Point, MD	$83.7M	*	Community Living Center: Dependent on the number of women residents
West LA, CA Building 208	$35M	$35M	Women's Homeless Housing
American Lake, WA	$11M	$0	NA—Engineering Admin/Shop
San Francisco, CA	$158M	$0	NA—Research
Long Beach, CA	$161M	*	Community Living Center: Dependent on the number of women residents
Alameda, CA Site Prep	$70M	$0	NA—Site work
Livermore, CA Stockton OPC	$139M	$880K	Women's Specialty is part of Patient Aligned Care Teams (PACT)
St. Louis (Jefferson Barracks), MO.	$90.1M	*	Women Veterans are seen throughout the entire facility for all of their treatment
Louisville, KY	$75M	$0	NA—Site work
National Cemetery Projects at Bayamon, PR; Portland, OR; Riverside, CA; and Pensacola, FL.	—	*	The FY 2016 National Cemetery Administration (NCA) major construction projects ensure eligible Veterans have access to burial options within a reasonable distance from their residence. These FY 2016 NCA major construction projects support all eligible Veterans and their families (to include female Veterans and dependents) by providing a final resting place.

*Amount of funding is dependent on the number of women Veterans served.

a. The FY 2015 enacted amount for construction was $1.057B and the FY 2016 request is for $1.55B or an increase of $493M. How much of this increase is due to the massive cost overruns on the Denver VA Hospital? I ask this because the project is estimated to cost an additional $500M to $1B more than original cost estimates.

Response. No funding in the FY 2016 budget is for the Denver hospital.

Question 62. Dr. Clancy and Mr. Warren, I believe VA pharmacy system has some major shortcomings, especially in the area of information technology. For example, VA pharmacies are not networked and when a veteran uses multiple VAMC/CBOCs or moves their home to a new location, this often times is a problem. What is the VA doing to help modernize the VA pharmacy system?

a. Do you have an estimate on what it would cost to network the VA pharmacies in a manner that would resemble how many of the large retail pharmacy (Wal-Mart) chains are networked?

Response. In many ways, the Department of Veterans Affairs' (VA) pharmacies are already networked. They all use a single VA national drug formulary; they all use VA's Consolidated Mail Outpatient Pharmacies to process and mail non-urgent prescriptions; they all have access to the same drug prices through the pharmaceutical prime vendor; they all use the same Veterans Health Information Systems and Technology Architecture (VistA) pharmacy software; and they all have visibility of prescriptions filled at other VA medical facilities. VA pharmacy staff is also currently able to see when a particular prescription was last filled by VA and where it was filled.

VA pharmacies cannot currently refill a prescription issued at a different VA facility automatically; deduct that refill from available refills; and record the refill in the VistA record at the issuing facility. VA pharmacies have developed workarounds over the years to address the medication needs of traveling Veterans who run out of medications; however, these workarounds take time and are inconvenient to Veterans and staff because they generally involve generating a new prescription and providing a new fill.

VA is currently working on an innovation project that will make the prescriptions, that VA pharmacies can now only review, actionable for refills. This will eliminate the need for workarounds, will make the process easier and faster and will provide an audit trail of these refills. This innovation is referred to as One VA Pharmacy.

VA is also exploring the possibility of establishing a network with retail pharmacies for prescriptions filled in these pharmacies under VA programs including PC3, CHOICE, ChampVA, CBOCs, etc. If this is established, VA will be able to integrate non-VA pharmacy workload records into VistA in the same way a prescription drug hub, like Surescripts, can do.

b. Dr. Clancy, do you believe that having a modern integrated pharmacy network would eventually yield cost savings in the way VA buys and dispenses medication?

Response. As noted above, VA is also exploring the possibility of establishing a network with retail pharmacies for prescriptions filled in these pharmacies under VA programs including PC3, CHOICE, ChampVA, and CBOCs. We believe this capability is analogous to the "modern integrated pharmacy network" that is referred to in the question If thisis established, VA will be able to integrate non-VA pharmacy workload records into VistA in the same way a prescription drug hub, like Surescripts, can do, providing VA prescribers with greater visibility of the totality of prescription drug therapy for Veterans.

VA believes such improvements can result in better convenience and the potential for better quality of care. Whether it would yield cost savings cannot be determined, as that would depend on the detailed capabilities of the system and the arrangements with retail pharmacies struck under such a network.

c. Mr. Warren, is it correct to say that VA currently does not have an electronic prescription capability? Something like Surescripts?

i. Is the VA considering investing in an electronic prescription system?

ii. If so, would it be your intent to buy an already available commercial off the shelf program or would VA design their own system? Have you already explored this issue?

Response. (i) As noted above, VA is also exploring the possibility of establishing a network with retail pharmacies for prescriptions filled in these pharmacies under VA programs including PC3, CHOICE, ChampVA, and CBOCs. We believe this capability is analogous to the "modern integrated pharmacy network" that is referred to in the question If thisis established, VA will be able to integrate non-VA pharmacy workload records into VistA in the same way a prescription drug hub, like Surescripts, can do, providing VA prescribers with greater visibility of the totality of prescription drug therapy for Veterans. We assume this capability is what is being referred to in the question as "an electronic prescription system."

(ii) VA would certainly consider using commercial off the shelf programs, if they offered sufficient compatibility, interoperability, and integration with VA's pharmacy infrastructure. However, VA has not proceeded far enough into its considerations to come to any conclusion on this question.

Question 63. Dr. Clancy, within VHA, there has been an effort to reduce the use of psychotropic and opioid medication to treat mental illness and chronic pain respectively. Many organizations and Members of Congress want to see VA take a more holistic approach to treating these conditions and not simply rely upon medication which has been overprescribed and abused in the past. What new and existing programs does VHA seek to fund to address this issue?

Response. The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) currently supports two programs that address safe and effective use of psychotropic and opioid medications across the system, the Psychotropic Drug Safe-

ty Initiative (PDSI) and the Opiate Safety Initiative (OSI). The Psychotropic Drug Safety Initiative (PDSI) is a Nation-wide psychopharmacology quality improvement (QI) initiative coordinated through the Office of Mental Health Operations (OMHO) in collaboration with Mental Health Services (MHS) and Pharmacy Benefits Management (PBM).

The PDSI aims to improve the safety and effectiveness of psychopharmacological treatment in VHA by focusing on avoiding overprescribing, addressing problems in clinical management, eliminating misalignment between prescribing and diagnosis, and decreasing missed opportunities for providing evidence-based care. The PDSI supports local psychopharmacology QI initiatives at facilities across the country by developing measures and providing data on prescribing practices, providing feedback and guidance on QI action plans, establishing a collaborative community of practice, and creating tools to identify Veterans who may benefit from clinical review of current psychotropic drug treatment.

The OSI is a multicomponent national intervention which consists of: (1) tools to identify underutilized clinical practice guideline-recommended pain treatments and opioid risk mitigations strategies for local implementation at the facility level; (2) tools to facilitate case review of higher risk patients at the provider level; (3) innovative clinical education programs to improve pain management and opioid prescribing practices (e.g. via SCAN-ECHO, webinar and academic detailing based programs); and (4) national initiatives to implement standardized informed consent practices and use of overdose education and Naloxone distribution for patients receiving or using opioids.

Collaboration across the PDSI and OSI are coordinated through an overarching steering team, which is made up of a multidisciplinary group of leaders from mental health, pain management, and pharmacy. VHA will monitor the effectiveness of these programs going forward to determine if any additional initiatives are needed and to identify any additional resource requirements.

a. Are there additional programs and initiatives that you would to pursue but are unable to because of budget constraints? If so, what are they?

Response. The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) has begun adding licensed acupuncturists and massage therapists to the list of VA occupations. VHA is also developing the qualifications standards and guidance that will allow local facilities to hire these types of providers as a means to augment existing evidence based care.

The main barriers to adding programs is not budget, but the scarcity of data to support expansion of complementary and integrative practices in the management of conditions such as Post Traumatic Stress Disorder. The current evidence supports these medical care services as possible adjuncts to existing evidence based therapies. There is some promising information for the use of complementary and integrative practices as adjuncts in the management of pain. However, the strength of the data to support these practices as well as the lack of occupational classes for the hiring of complementary and integrative providers are the major barriers to the expansion of this type of care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BILL CASSIDY TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 64. In testimony, it was stated that 20% of the reported number of clinic visits across the VA system were actually "no-shows." A "no-show" is a missed appointment in which the patient does not show up for the appointment. Dr. Clancy then said two things which were contradictory. First, she said that the VA can only determine no-show rates for the entire system and not by institution. Then, she said that "no show" rates are higher for non-rural VA facilities. This suggests that a facility-specific analysis is possible and is being conducted. Please reconcile these differences and answer the following questions.

a. If a facility-specific finding is not possible, how are the cumulative statistics established/collected?

b. If facility specific statistics are truly not available, why are they not collected? This seems like a simple query—sorting attendance rates by facility to establish a ratio between "no shows" and the total number of visits scheduled. Is the VA database unable to do this?

Response. No-shows (also called "missed opportunities") occur when a patient scheduled for an appointment does not attend. The Department of Veterans Affairs' (VA) databases hold information on each individual appointment, including no-shows. The statistics are collected through the Veterans Health Information System and Technology Architecture (VistA) scheduling system when each appointment is

processed. Therefore, VA can calculate no-shows by individual patient, clinic, facility, Veteran Integrated Service Network (VISN), etc. VHA's highest facility no-show rates tend to be at large facilities in larger urban areas.

Question 65. On August 11, 2014, FDA found safe and effective and CMS authorized for Medicare coverage for a new DNA stool based non-invasive colorectal cancer test. In January 2015 an application was made to the Federal Supply Service (FSS) program for availability in the VA health system. Based on study published in the New England Journal of Medicine in April 2014 the test founded 94% of Stage I and Stage II cancer and 69% of advanced pre-cancer. Currently VA relies on a much less accurate non-invasive test (FOBT/FIT) that requires a repeat of the test every year for five years. Peer review studies have found that adherence to the test is very disappointing. By year 4 only 14% of the more than 300,000 veterans whose records were examined have adhered to the test i.e. repeated it annually for four years. It takes one year for VA to process any new medical item for inclusion in the Federal Supply Schedule. The VA has been delegated the responsibility for medical items by the General Services Administration (GSA). Given VAs well documented problems with colorectal cancer screening, the innovative nature of the test and the poor adherence to the existing test, can the process be expedited on the basis of offering new technology to our veterans?

Response. There is an active procurement action ongoing through the FSS multiple award schedule program, which means more than one company is awarded a contract for the same or similar products and/or services. While this action occurs, this DNA stool-based colorectal cancer screening test may be obtained by the medical centers as necessary, in compliance with prescribed acquisition regulations and policies.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JON TESTER TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 66. Early in FY 2014 the Montana VA experienced a backlog in inpatient claims. By the close of the fiscal year, a significant backlog in payments to providers like Kalispell Regional Health, still remained. To what extend did the VA carry a backlog of unfunded claims into FY15?

Response. In June 2014, the Department of Veterans Affairs (VA) held a meeting with the Montana Independent Hospital Association partners. The non-VA care (NVC) claims processing manager collaborated directly with the independent hospitals. During this meeting, a discrepancy was discovered between VA processing center's recorded claims and the independent hospital's aged accounts receivables. The parties worked together to reconcile results and allowed the hospitals to clear aged accounts. Recurring calls, began in June 2014, and currently continue between the independent hospitals and the payment processing center.

Average claim timeliness has increased slightly. In June 2014, there was an average of 32 days to process a claim. Currently, the average is 35 days.

As of March 19, 2015, Montana had 23,969 claims on hand. 90.40% of those claims were under 30 days old. There were no claims over 365 days old.

Question 67. Funding by the U.S. Treasury for FY 2014 claims in Montana appears to be sporadic and incomplete. For Kalispell Regional Health and other hospitals, these claims represent the oldest claims and present the greatest impact to cash-flow and bond ratings. Some of these claims have been awaiting payment for nearly one year, as Kalispell Regional Health's own fiscal year closes in March 2015. Now that FY 2014 is closed, how are the FY 2014 claims funded in FY15?

Response. There has been significant growth in the non-VA care in the VA Montana Health Care System resulting in temporary backlogs. Actual expenditures have exceeded the estimated costs for non-VA care. Additional funds were identified in other accounts and supplemental funding was requested and received to process fiscal year 14 obligations.

Question 68. Is there more we can do to support the VA to facilitate fast, complete turn-around for full payment for these claims by the Treasury? To what extend is the VA taking steps to work directly with civilian providers to streamline and improve the claims process to prevent future backlogs?

Response. The Department of Veterans Affairs (VA) has begun the process of streamlining and improving non-VA medical care claims processing to prevent future backlogs. VA has recently consolidated all claims processing operations VA's Chief Business Office. The desired outcome is a more consistent and effective claims processing division.

The payment of claims begins with non-VA providers timely filing a complete bill. A complete bill includes accurate and complete claim information along with any supporting medical documentation that has been requested. The filing of a complete bill prevents the rejection of the claim and a subsequent request for missing documentation. Non-VA providers are also encouraged to submit their claims electronically to expedite this process. If non-VA medical care providers are receiving mailed paper checks from Treasury, enrolling in electronic funds transfer (EFT) payments will eliminate several days for payment receipts.

VA understands that partnering with non-VA medical care providers is critical for successful claims processing. Therefore, VA has also taken steps to educate our partners on a range of topics through our Non-VA Medical Care Provider Web site (http://www.va.gov/PURCHASEDCARE/programs/providerinfo/index.asp) and email distribution list. Locally, Veterans Affairs Medical Centers (VAMC) provide continuous outreach to medical providers to improve the claims processing system.

Question 69. What steps can civilian providers and the VA take to work together proactively to prevent payment backlogs in 2015?

Response. The Department of Veterans Affairs (VA) believes that effective communication between non-VA medical care providers and VA is critical to prevent improper payments and backlogs.

To further prevent payment backlogs, non-VA medical care providers should submit accurate and complete claim information along with any supporting medical documentation that has been requested. Ensuring accurate and complete claims are filed will prevent the rejection of the claim and a subsequent request for missing documentation. Non-VA providers are also encouraged to submit their claims electronically to expedite this process. If non-VA medical care providers are receiving mailed paper checks from Treasury, enrolling in electronic funds transfer (EFT) payments will eliminate several days for payment receipts.

VA's Chief Business Office's (CBO) Purchased Care (PC) department maintains an external Web site with a designated provider page to support VA's non-VA medical care partners (http://www.va.gov/PURCHASEDCARE/programs/providerinfo/index.asp). This page delivers the following useful information:

- Provider guidebook that details what non-VA medical care providers should expect in terms of authorizations, referrals, claims payments, and the return of medical documentation back to the authorizing VA medical center
- Instructions on how to file a claim, including using the Electronic Claims submission process
- Detailed information on authorization for pre-authorized care
- Detailed information on claims processing for emergency medical services
- How to read a preliminary fee remittance advice report (PFRAR)
- Definitions of denial codes and reasons

VA has also launched an email distribution list so providers can stay up to date with the non-VA medical care program. Helpful information is provided to those on our community provider email distribution list about doing business with the VA at least once per month.

Additionally, local VA and non-VA medical care providers can effectively communicate to address specific issues that arise. For example, if a large volume of claims are being denied, VA and non-VA providers can work together to assess why claims are being rejected and ensure the needed information is submitted.

Question 70. Also, I understand that the VHA is considering granting Full Practice Authority to Advanced Practice Registered Nurses including Certified Registered Nurse Anesthetists and Nurse Practitioners. This is a policy I support as it would follow recommendations from the Institute of Medicine and align with current practice in the Army, Navy, Air Force, Combat Support Hospitals and the Indian Health Services. What is the current status is of the VHA Nursing Handbook?

Response. The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) is developing a draft nursing handbook proposing the authorization of full practice authority (FPA) for advanced practice registered nurses (APRN) without regard to individual State Practice Acts, except for the dispensing, prescribing, and administration of controlled substances. This proposed change to nursing policy would standardize APRN practices throughout VA's health care system and increase access to high quality care for all Veterans. Implementation of FPA would increase patient access by alleviating the effects of national health care provider shortages on VA staffing levels and enable VA to provide additional health care services in medically-underserved areas. VHA intends to implement this change to our policy through regulatory action to ensure its enforceability and allow the public the opportunity to provide comments. VHA is developing a draft regulation that would recognize FPA for APRNs, including CRNAs. The draft regulation will be published in

the *Federal Register* as a proposed rule for notice and comment. Following the public comment period, VA will review the comments received and consider whether to revise the regulation before publishing it as a final rule. VHA believes in being transparent when making health care delivery decisions and welcomes the opportunity to discuss policy concerns.

Chairman ISAKSON. The second panel will come forward, please. [Pause.]

I apologize to the second panel for the length and duration of the questioning of the Secretary, but we probably will not have a more important time this year or this session of Congress to deal with that, so I was liberal with time. That said, I am going to make sure everybody's testimony gets in for the record before we have to go for a vote or are interrupted. I appreciate your patience, and please understand, the length of that was in no way meant to contrive what you do, but we had to see what the Secretary had to say.

What we are going to do is go straight to your testimony, one after another, and we will take it all in. Then, as we have time for questions afterwards, we will do that. I would ask you to try to hold your comments within that 5-minute range, but if you go over just a tad, that is all right until I rap the gavel and call you to stop.

First will be Carl Blake, Paralyzed Veterans of America. Next will be Ms. Ilem?

Ms. ILEM. Ilem.

Chairman ISAKSON. Ilem. It is a beautiful name for a beautiful lady. We are glad to have you here today.

Mr. Kelley, we are glad to have you.

Mr. de Planque, I saw you a lot yesterday. It is good to see you again. We are glad to have Ian—and it is de Planque, right? I got it right?

Then, Richard Weidman of Vietnam Veterans of America, thank you for being here today.

We will start with you, Mr. Blake.

STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Mr. Chairman. Let me begin by saying I do not feel slighted by having the Secretary, who is the head of a Cabinet-level agency, being elevated above the level of the veterans service organizations for consideration, so we do not have any problem with that.

I would like to thank you again for the opportunity to testify. I am here to represent both Paralyzed Veterans of America and the co-authors of the *Independent Budget*. We released recently our *Independent Budget* report for fiscal year 2016 and 2017. With the Chairman and the Committee's permission, we would like to submit that report into the official hearing record.

Chairman ISAKSON. Without objection.

Mr. BLAKE. Thank you.

[The *Independent Budget* report can be found in the Appendix.]

Mr. BLAKE. I would just say that we believe that the VA's budget for this year is a very good budget. We appreciate the fact that the administration seems, for the first time, in my view, to have taken

seriously their responsibility when it comes to reviewing advanced appropriations and making necessary revisions. This was the first year since it was enacted there has been a substantial revision to the advanced appropriations recommendations. The recommendations are fairly close even to what the *Independent Budget* has recommended. The same would be true for fiscal year 2017.

I have a number of other comments that I was going to make, but I think I would rather turn my attention to some of the discussion that has been held here today on a couple of topics.

Obviously, the hot topic has been the Choice Act. Something you said at the beginning about getting on board, helping make this program work, I can tell you, Mr. Chairman, that I believe everybody at this table with many of the other veterans service organizations were involved with the VA from the day that the bill was passed last August to try to get this right in the implementation. We had a number of meetings with the VA, talked through all kinds of questions.

One of the common questions was the concept of 40 miles for service versus 40 miles from a facility. I will tell you that the bill specifically says, "An eligible veteran is a veteran who resides more than 40 miles from a medical facility of the Department, including a community-based outpatient clinic, that is closest to the residence of the veteran." That is the specific language of the bill.

Obviously, there is some opening for interpretation. Everybody would like to see it, I think, maybe in the direction of service. It makes sense, we believe. However, what I would say is—and Chairman Miller pointed this out yesterday. Congress had a hard time with that concept because when CBO tried to cost it, the potential cost for that concept was astronomically higher than this bill as passed was. So, that is a challenge, we believe, that Congress is going to have to grapple with.

From the perspective of PVA, it is no secret that we have not been a big proponent of privatizing VA care or purchasing care outside the VA system. However, that being said, I am disappointed Mr. Moran is not still here. Kansas is a case study in the failing of the VA in the past in fee-based or purchased care. It has boggled my mind for years because I have listened to Senator Moran and I have listened to Mr. Huelskamp on the House Committee, rail over and over again about why veterans, particularly in western Kansas, but over a large part of Kansas, cannot get access to care or are being forced to drive 200, 300, and 400 miles in some cases to get care at a VA facility. I just cannot even fathom how that could happen. Even under the old rules of fee-based care, seemingly that occurrence would not happen; yet, it did. So, it would stand to reason that something like Choice would help alleviate some of those problems.

We are interested in working with this Committee, with the House Committee, and with the VA to get it right. But, there are some steps that we believe Congress is still going to have to take if it really wants to go the full step. And it has to keep in mind that while Choice seems like a good idea for most veterans—veterans like the membership that I represent—veterans with spinal cord injury, do not really have a viable choice. There are facilities around the country that exist in the private system, but they do

not provide care like the VA's spinal cord injury system of care. So, you have to consider that in any further decision about the future delivery of VA health care.

The last thing I would comment on is there was a question about the culture of VA and changed leadership. The Secretary mentioned changed leadership. I would point out that two of the three Under Secretaries for Health are in an interim status currently. Dr. Clancy has been in this position since this basically broke last summer and has been charged with helping shepherd through a lot of monumental changes in the VA health care system that her predecessor was not involved in. Her predecessor had the opportunity to walk away, wipe his hands, when the damage was already done. Dr. Clancy has done a great job. PVA has already come out on the record saying Dr. Clancy should be made the permanent Under Secretary for Health, but somebody should be made the permanent Under Secretary for Health.

I would also suggest that at a level lower than that, there is still an acting position for the Chief Consultant for the Spinal Cord Injury Service. That is the person charged with making sure the policy and procedure that goes on within the SCI system of care is appropriate, timely, efficient, and delivers the best service for veterans. It makes no sense that that person is not in a permanent status. It is time for that to be corrected.

I think if you start putting people in place who have the best interests of change in mind, then you can make change. But, that is the only way you are going to get the culture to turn around in any meaningful way.

With that, Mr. Chairman, I would like to thank you for the opportunity to testify, and I would be happy to answer any questions you have.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee: As one of the four co-authors of *The Independent Budget* (*IB*), Paralyzed Veterans of America (PVA) is pleased to present the views of *The Independent Budget* regarding the funding requirements for the Department of Veterans Affairs (VA) for FY 2016 and advance appropriations for FY 2017. The *IB* veterans service organizations (IBVSO) recently released our report *The Independent Budget* for the Department of Veterans Affairs for FY 2016 and FY 2017. This report offers detailed recommendations for all of the principle line items of the VA budget. We would ask to make that complete report part of the official hearing record.

The IBVSOs believe that the VA's budget request this year is largely a very good budget. We appreciate the fact that VA appears to have made an honest assessment and revision to the medical care accounts for FY 2016. Unfortunately, we believe the advance appropriations amount for FY 2016 provided for by Congress in the "FY 2015 Consolidated and Further Continuing Appropriations Act" approved in December 2014 is not sufficient to meet the full demand for services being placed on the system. For FY 2016, the *IB* recommends approximately $63.3 billion for total Medical Care. However, Congress recently approved only $62 billion for total Medical Care (based on an assumption that includes approximately $3.2 billion for medical care collections). The VA has now revised their FY 2016 Medical Care estimate to $63.2 billion. We encourage the Committee to give serious consideration to these revisions and we will be calling on the Senate Committee on Appropriations to address the shortfall that was previously approved through advance appropriations.

Additionally, *The Independent Budget* recommends an advance appropriation of approximately $66.4 billion for total Medical Care for FY 2017. We are pleased to see that the Administration has requested approximately $66.6 billion (including ap-

proximately $3.3 billion in medical care collections) for advance appropriations for FY 2017. We encourage the Committee to affirm these estimates in its Views & Estimates to the Senate Committee on Appropriations.

The IBVSOs would also offer some concerns that we see with the Administration budget. *The Independent Budget* recommendations focus on recommendations at the point of service, but we believe that administrative costs across the board must continue to be reined in. We would highlight the clear differences between our recommendations for such line items as Medical Support and Compliance, General Administration and Information Technology (IT) to affirm this point. These line items focus a great deal of resources on administrative support, and all three of these accounts reflect significant increases in resources for FY 2016 and in the FY 2017 advance appropriations for Medical Support and Compliance. We encourage the Committee to do a thorough analysis of those accounts specifically to ensure that dollars appropriated for those accounts are allocated efficiently and effectively.

FUNDING FOR FY 2016

For FY 2016, *The Independent Budget* recommends approximately $51.6 billion for Medical Services. This recommendation is a reflection of multiple components. These components include the following recommendations:

Current Services Estimate	$49,468,647,000
Increase in Patient Workload	$1,489,858,000
Additional Medical Care Program Costs	$635,000,000
Total FY 2016 Medical Services	$51,593,505,000

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. The estimate also assumes a 1.5 percent increase for pay and benefits across the board for all VA employees.

Our estimate of growth in patient workload is based on a projected increase of approximately 148,000 new unique patients. These new unique patients include priority group 1–8 veterans and covered nonveterans as well as additional new users as a result of veterans being removed from the extended waiting lists and those whose decisions on healthcare enrollment eligibility are made. We estimate the cost of these new unique patients to be approximately $1.2 billion. The increase in patient workload also includes a projected increase of 71,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) enrollees, as well as Operation New Dawn (OND) veterans at a cost of approximately $282 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users from FY 2002 through the 4th quarter of FY 2014.

The Independent Budget believes that there are additional projected medical program funding needs for VA. Specifically, we believe there is real funding needed to address the array of long-term-care issues facing VA, including the shortfall in institutional capacity; to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service); as well as funding necessary to improve the Comprehensive Family Caregiver program; and funding to address needed improvements in programs directed for women veterans.

The Independent Budget recommends $325 million directed toward VA long-term-care programs. In order to support the continued rebalancing of VA long-term care in FY 2016, $125 million should be provided. Additionally, $95 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the $325 million ($105 million) should be dedicated to increasing the VA's long-term-care average daily census (ADC) to the level mandated by Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act."

In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $150 million. This increase in prosthetics funding reflects an increase in expenditures from FY 2014 to FY 2015 and the expected continued growth in expenditures for FY 2016. Our additional program costs recommendation includes investing $70 million in the Comprehensive Family Caregiver program in accordance with the deficiencies identified during the hearing held by the House Veterans' Affairs Subcommittee on Health in December 2014. The Medical Services appropriation should also be supplemented with $90 million designated for women's healthcare programs, in addition to those amounts already included in the FY 2016 baseline. These funds would be used to help the Veterans Health Administration deal with the continuing growth in ensuring coverage for gynecological, prenatal,

and obstetric care, other gender-specific services, and for maintenance and repair of facilities hosting women's care to improve privacy and safety of these facilities where women seek care. The new funds would also aid the VHA in making its cultural transformation to embrace women veterans and welcome them to VA healthcare services, and provide means for VA to improve specialized mental health and readjustment services for women veterans.

For Medical Support and Compliance, *The Independent Budget* recommends approximately $6.0 billion for FY 2016. Our projected increase reflects an increase in current services based on the impact of inflation on the FY 2015 appropriated level. For Medical Facilities, *The Independent Budget* recommends approximately $5.7 billion for FY 2016, nearly $800 million more than the enacted advance appropriations in December 2014. Our Medical Facilities recommendation includes the addition of $900 million to the baseline for Non-Recurring Maintenance (NRM). The Administration's request over the past two cycles represents a wholly inadequate request for NRM funding, particularly in light of the actual expenditures that are outlined in the budget justification. While VA has actually spent on average approximately $1.3 billion yearly for NRM, the Administration has requested only approximately $460 million for NRM. This decision means that VA is forced to divert funds designated for another purpose to meet this need.

ADVANCE APPROPRIATIONS FOR FY 2017

The Independent Budget once again offers baseline projections for funding through advance appropriations for the Medical Care accounts for FY 2017. For FY 2017, *The Independent Budget* recommends approximately $54.2 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$51,937,260,000
Increase in Patient Workload	$1,576,151,000
Additional Medical Care Program Costs	$670,000,000
Total FY 2017 Medical Services	$54,183,411,000

Our growth in patient workload is based on a projected increase of approximately 150,000 new unique patients. These new unique patients include priority group 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $1.3 billion. This recommendation also reflects an assumption that more veterans will be accessing the system as VA expands its capacity and services and we believe that reliance rates will increase as veterans examine their healthcare options as a part of the option for choice. The increase in patient workload also includes a projected increase of 74,225 new OEF/OIF, as well as OND veterans at a cost of approximately $301 million.

As previously discussed, the IBVSOs believe that there are additional medical program funding needs for VA. *The Independent Budget* recommends $325 million directed toward VA long-term-care programs. In order to support the continued rebalancing of VA long-term care in FY 2017, $125 million should be provided. Additionally, $95 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the $325 million ($105 million) should be dedicated to increasing the VA's long-term-care average daily census (ADC) to the level mandated by Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act." In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $165 million. Our additional program costs recommendation includes continued reinvestment of $75 million in the Comprehensive Family Caregiver program. Finally, we believe that VA should invest a minimum of $105 million as an advance appropriation in FY 2017 to expand and improve access to women veterans' healthcare programs.

Additionally, for FY 2017 *The Independent Budget* recommends approximately $6.2 billion for Medical Support and Compliance. *The Independent Budget* also recommends approximately $5.9 billion for Medical Facilities for FY 2017. As with FY 2016, our FY 2017 recommendation includes the addition of $900 million to the baseline for NRM. Last year the Administration's recommendation for NRM reflected a projection that would place the long-term viability of the healthcare system in serious jeopardy.

MEDICAL AND PROSTHETIC RESEARCH

The Independent Budget co-authors have ongoing concerns about the lack of investment in Medical and Prosthetic Research. We appreciate the fact that this year

the Administration recommended a substantial increase in research funding. For FY 2016, the Administration recommends approximately $622 million while the *IB* recommends approximately $619 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 healthcare 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.

GRANTS FOR STATE EXTENDED-CARE FACILITIES

The State Veterans Home program (State Homes) 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. Today, State Homes provide over 30,000 nursing home and domiciliary beds for veterans, their spouses, and gold-star parents of veterans. Overall, State Homes provide approximately 53 percent of VA's long-term-care workload, for the very reasonable cost of only about 12 percent of VA's long-term-care budget. On average, the daily cost of care for a veteran at a State Home is less than 50 percent of the cost of care at a VA long-term-care facility. This basic per diem covers about 30 percent of the cost of care, with states responsible for the balance, utilizing both state funding and other sources.

VA also provides states with construction grants to 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 qualify are included in VA's Priority List Group 1 projects, which are eligible for funding. Those who have not yet received assurances of state matching funding are put on the list among Priority Groups 2 through 7.

In FY 2014, the estimated Federal share for proposed State Home Construction Grants submitted by states was $928 million, of which $489 million had already secured the state matching funds required to put them in the Priority Group List 1. In FY 2015, total estimated share of State Home Construction Grant requests rose to $976 million, of which $409 million already have state matching funding. The IBVSOs had recommended $250 million to provide funding for about half of the Priority 1 projects. The final appropriated funding for FY 2014 was only $85 million and only $90 million for FY 2015. For FY 2016, the IBVSOs recommend $200 million for the State Home Construction Grant program, which we estimate would provide sufficient funding for approximately half of the projects expected to be on the FY 2016 VA Priority Group 1 List when it is released at the end of this year.

We encourage the Committee to scrutinize the VA's budget with vigor. However, we believe than honest analysis will show that these are the resource needs of VA. As such, we believe that the real focus of the Committee should be on scrutinizing how the VA spends these critically needed resources. It is imperative that these dollars ensure that veterans receive timely, quality health care and claims decisions that are right the first time.

In the end, it is easy to forget that the people who are ultimately affected by wrangling over the budget are the men and women who have served and sacrificed so much for this Nation. We hope that you will consider these men and women when you develop your budget views and estimates, and we ask that you join us in adopting the recommendations of *The Independent Budget*.

This concludes our statement. I would be happy to answer any questions you may have.

Chairman ISAKSON. Thank you for your testimony and for your support of veterans and what you do for paralyzed veterans. We appreciate it very much.

Ms. Ilem.

STATEMENT OF JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. ILEM. Chairman Isakson, on behalf of DAV, I am pleased to present the fiscal year 2016 recommendations of the *Independent Budget* for the Veterans Benefits Administration.

Without question, over the past 5 years, VBA has achieved some remarkable progress. The fully developed claims program, disability benefits questionnaires, and the Veterans Benefits Management System, known as VBMS, have all made significant contributions. Five years ago, no claims were processed electronically. Today, more than 93 percent of VBA's roughly 500,000 pending claims are fully electronic.

Likewise, VBA has made significant progress related to its target goal of completing disability claims within 125 days, with a 98-percent accuracy standard. From its peak in 2013, the total number of pending claims has been reduced by 40 percent, and the backlog claims pending over 125 days cut by over 60 percent. And I would mention at this point, as well, I think General Hickey has done an excellent job. She has worked tirelessly with the VSO community, and a lot of these changes have been really put on her, and she has not let up during her time.

At the same time, according to VBA, the accuracy of decisions rose from 86.4 percent 2 years ago to 91 percent at the beginning of this year.

Mr. Chairman, while it is unclear if VBA can achieve its goals by the end of 2015, in our opinion the most critical factor in VBA's ability to address the backlog is sufficient staffing. Over the past several years, many VA regional offices have required mandatory overtime and diverted some of their senior employees from both quality review and appeals work to focus on claims processing. The reliance on mandatory overtime in this supplemental claims processing workforce is a clear indicator to us that VBA is insufficiently staffed to handle its current workload.

In order to increase productivity now while allowing for future efficiencies from technology, we propose the VBA be provided 1,700 additional full-time employees, half of them permanent and the other half under a 2-year temporary authority. At the end of the 2-year period, VBA could make permanent the best of these temporary employees for positions that may open from attrition.

While VBMS has generally been a success, current planning at VBA has delayed development of some critical IT elements, including the major modules to allow electronic transmission of medical examinations and service treatment records. Therefore, the IBVSOs have recommended a $60 million increase for IT funding for VBMS and other critical IT enhancements.

While the claims backlog has been reduced, the backlog of pending appeals is now rising. Last year, the board completed a record over 55,000 appellate decisions, but there are still nearly now 300,000 appeals in VBA at various stages working their way toward the board. For these reasons, we recommend an increase of 120 new full-time employees for the board.

In addition, the IBVSOs recommend that at least $15 million be allocated for IT modernization to aid the board's transition to digital processing of appeals.

Mr. Chairman, to address the issue of rising appeals, the *Independent Budget* groups here, other VSO stakeholders, VBA, and the board worked together collectively to develop a new proposal called "fully developed appeals," or FDA, modeled after the fully developed claims program. The veteran would agree to assemble private evidence and arguments to satisfy their appeal, eliminate some VBA processing steps, and agree not to request a hearing. In exchange, they could save up to 2 to 3 years of processing time. The FDA program would be completely voluntary, and the veteran could withdraw from it at any time without losing any right to a traditional appeal. We think this option will help expedite many of these appeals and, therefore, urge the Committee to move legislation to create a new FDA pilot program.

Another critical program for veterans, particularly disabled veterans, is the Vocational Rehabilitation and Employment Service. In 2016, the IBVSOs project a nearly 10-percent increase in that participant growth; therefore, we recommend an additional 382 full-time employees be added to the program, of which 277 would be dedicated as counselors and 105 dedicated to support services.

Finally, the *IB* policy agenda for the 114th Congress contains a number of additional policy recommendations we hope the Committee will consider, including the elimination of the rounding down of the COLA for veterans and survivors' benefit programs—or payments, and increasing Dependency and Indemnity Compensation rates for survivors, eliminating the DIC and Survivor Benefit Plan offsets, and allowing widows to have their benefits continue or restored if they remarry after age 55.

That completes my statement. I am happy to answer any questions.

[The prepared statement of Ms. Ilem follows:]

PREPARED STATEMENT OF JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLE AMERICAN VETERANS

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee: On behalf of the DAV and our 1.2 million members, all of whom were wounded, injured or made ill from their wartime service, I am pleased to present recommendations of *The Independent Budget* (*IB*) for the fiscal year (FY) 2016 budget related to veterans' benefits and the Veterans Benefits Administration (VBA). The *IB* is jointly produced each year by DAV, AMVETS, Paralyzed Veterans of America and Veterans of Foreign Wars of the United States. This year's *IB* Budget Report as well as the *IB*'s Policy Agenda for the 114th Congress contain numerous recommendations to improve veterans' benefit programs and the claims processing and appeals system; however, in today's testimony I will highlight just some of the most critical ones for this Committee to consider, particularly those requiring new resources.

Mr. Chairman, five years ago the Veterans Benefits Administration (VBA) set out to transform and modernize its systems and procedures for processing veterans' claims for benefits, particularly for disability compensation. Then-VA Secretary Shinseki announced ambitious "aspirational goals" for transforming the claims system, promising that by the end of 2015 VBA would decide all claims for disability compensation within 125 days and that they would be completed to a 98% accuracy standard. This aspirational goal soon became enshrined as VBA's bedrock strategic target, against which all of its plans and progress would be measured.

Today, with less than a year remaining, there are questions about whether either of those goals can be achieved.

VBA HAS MADE PROGRESS IN TRANSFORMING CLAIMS PROCESSING

Mr. Chairman, unquestionably, over the past five years VBA has achieved remarkable progress, much of it visible and measurable. A new organizational model has been implemented, new technologies deployed and new business processes

adopted. The fully developed claims (FDC) program started as a pilot test, and now about 40 percent of all claims filed today are done through the FDC program. Standardized medical evidence forms known as Disability Benefits Questionnaires (DBQ) are now used universally, and are an essential component of creating an automated claims processing system. And the development and deployment of the Veterans Benefits Management System (VBMS) and its "e-Folder" have dramatically enhanced VBA's ability to manage the volume of documents and information required to process over a million claims yearly. Today, VA receives more claims, processes more claims, has fewer claims pending in its inventory, has fewer claims in backlog status, takes less time to process claims, and issues decisions that are more accurate.

Five years ago, no claims were processed electronically; today with VBMS fully deployed to all 58 regional offices, more than 93% of VBA's roughly 500,000 pending claims are fully electronic. There have been more than one billion images scanned into VBMS or other VA systems, and both new and legacy claims documents and files continue to be converted into digital documents and uploaded into VBMS. Veterans' e-Folders in VBMS can be read at all VBA offices, including the Appeals Management Center (AMC) and Board of Veterans' Appeals (Board), as well as at 148 VHA facilities and by VSOs that represent veterans. About 75 percent of the rating schedule, which covers more than 93 percent of all rating decisions, has been coded into "calculators" and embedded in VBMS to assist Rating Veterans Service Representatives (RVSRs) make rating decisions.

Both e-Benefits and the Stakeholder Enterprise Portal (SEP) allow veterans and their authorized representatives to initiate, submit and track their claims online. These technological advancements have enabled VBA to make major improvements in the size of the backlog, the timeliness of claims and the accuracy of decisions; however, analysis of currently available data raises questions about whether the level and trends of progress are sufficient to meet VBA's 2015 goals.

According to VBA's Monday Morning Workload Analysis reports, at its peak early in 2013, the total number of pending claims for disability compensation and pension rose to over 860,000, with the backlog (those pending over 125 days) topping 600,000. As of last week, the total pending workload of claims was reduced by more than 40 percent to just under 500,000 and the number in backlog status was cut by over 60 percent down to about 230,000.

Based on data from the Aspire Dashboard, the timeliness of claims has also improved; however, this performance remains far short of the 2015 goal of all claims being completed in less than 125 days. In January 2013, the average processing time and the average days pending metrics were both approximately 280 days. By January 2015, the average days processing was down to about 200 days and the average days pending was about 150 days. However, it is important to point out that both of those timeliness measures are for "average" times, whereas VBA's 2015 target is based on all claims being completed with 125 days. To have all completed in 125 days might require an "average" processing time of 80 or 90 days. The current trends raise questions about whether this target can be achieved by the end of 2015.

Finally, the most important metric of a properly functioning claims processing system is the accuracy of decisions. After all, claims completed rapidly do a veteran little good if the decision results in a wrongful denial. In January 2013, VBA's claims accuracy based on its Systematic Technical Accuracy Review (STAR) was 86.4 percent for the 12-month average, and 86.8 percent for the three month average. Over the past two years, the accuracy rate had increased steadily reaching 91 percent for the 12-month measure ending in January 2015, and 91.5 percent for the 3-month measure. Among the reasons for these increases were sharpened focus on training, testing and quality control, including the creation of Quality Review Teams (QRTs), the dramatic reduction of Veterans Claims Assistance Act of 2000 (VCAA) "duty to assist" notification errors due to the inclusion of this notice directly on application forms, and the elimination of errors due to automation. However, whether it is possible to reach 98 percent accuracy for claims remains an open question, particularly as the average number of issues per claim continues to rise.

REALISTIC GOALS ARE KEY TO LONG-TERM SUCCESS

Overall, VBA has made significant progress toward reaching the 2015 goals; however, with less than a year remaining to reach those goals, VBA must openly and honestly assess whether those goals are still appropriate and achievable. Vital lessons must be learned from the VA's scandals last year of holding onto unrealistic and unachievable goals. The Veterans Health Administration's (VHA) access standard that outpatient appointments must be scheduled within 14 days of the patient's desired date, was widely viewed as unrealistic considering VHA's limited capacity

to provide timely care to new patients. Faced with the dilemma of an unreachable and unchangeable standard, some employees made the decision to manipulate data and cover up true waiting lists rather than be held accountable for failure to meet this standard.

The critical question that VA and Congress must confront now is whether the goals established five years are working to drive VBA's performance in a positive direction or whether it would be better for veterans and VA to review, reassess and if necessary, revise VBA's target goals before they start to distort behavior in the chase to meet these unreachable standards. If VBA concludes they are not, VBA must work in a transparent and collaborative manner with Congress and its VSO partners to set new goals, revise its strategies and plans, and request new resources if needed to reach those goals.

PERMANENTLY ENDING THE BACKLOG REQUIRES SUFFICIENT STAFFING

Recognizing that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel, Congress provided the VBA with more than 3,000 full time employee equivalents (FTEE) between 2008 and 2013, primarily in Compensation Service. However, relative to VBA's total workload, including appeals, these increases have not been sufficient to keep pace with rising workload, including non-rating work and appeals work, as evidenced by VBA's own resource allocation and personnel decisions.

VBA's largest increases in productivity—periods where the backlog declined most markedly—occurred while VBA enforced a policy of mandatory overtime for its workforce. During holiday periods, when mandatory overtime was curtailed, production fell off measurably. Furthermore, over the past couple of years many VA Regional Offices (VARO) have diverted some of their senior employees from both quality review and appeals work to focus on claims processing to drive down the backlog. Specifically, both Decision Review Officers (DRO) and Quality Review Specialists (QRS) have been performing claims development and rating duties during both regular and overtime working hours at many VAROs. The reliance on this supplemental claims processing workforce is a clear indicator that VBA is insufficiently staffed to handle its current workload.

A blend of technology and people will be necessary to provide veterans and their dependents with timely accurate decisions. Although this new claims processing system has the potential to transform the delivery and accuracy of benefits, some additional time will be required before the full effect of these changes will be realized. Therefore, in order to increase productivity now, while allowing for future productivity increases, the IBVSOs propose that VBA be provided with 1,700 additional FTEE, half of them permanent and the other half under a two-year temporary authority. The temporary FTEE request is based on an approach included in the stimulus legislation that was passed several years ago that allowed the VBA to hire several thousand employees for temporary, two-year terms. At the end of those two years, many of these temporary employees transitioned into permanent positions through staff attrition.

Allowing VBA to again hire employees for two-year temporary terms could supplement the staff and alleviate reliance on mandatory overtime, and further reduce the backlog of disability claims. Such an initiative would also provide an outstanding opportunity for VBA to develop a generous pool of trained, qualified candidates for succession of full-time positions vacated by employees leaving VBA.

While this infusion of resources is necessary to supplement the current workforce, the IBVSOs continue to believe that a more accurate staffing and production model is required to determine VBA's long-term resource needs as new technology and business processes evolve.

In FY 2016, the IBVSOs recommend providing VBA's compensation service with 850 new permanent FTEE and 850 two-year temporary FTEE. These additions will require an increase in appropriations of $158.9 million.

IT MODERNIZATION MUST BE ACCELERATED

The most critical elements of VBA's claims processing transformation are its new IT systems created over the past five years: VBMS, e-Benefits and SEP. These three systems have led the way in moving claims processing from an outdated paper-based system to the modern digital system. Despite early challenges, the VBMS program has proven to be an effective platform for processing claims in a digital environment. The objective now is to fully integrate all elements of the claims system, VSOs and other VBA business lines to create a unified digital work environment.

Current planning at VBA calls for some critical elements of the claims process, including major modules to allow electronic transmission to VBMS of examinations

and service treatment records from the Department of Defense, other government agencies, private businesses and other organizations, to be completed over the next several years. Although VBA could use these modules immediately, budget constraints have extended planning into future years. Similarly, plans to expand VBMS, or another compatible IT solution, to all remaining VBA business lines and the Board, are also being stretched out to future years due to lack of budget availability. We believe that Congress must provide sufficient resources to VBA now to allow these critical elements of VBMS and associated IT systems to be accelerated.

VBA must also place greater emphasis on integrating VSOs into VBMS and resolving lingering issues in SEP, both of which are essential to maximizing the benefits that VSO service officers offer in resolving claims more quickly and accurately.

The IBVSOs recommend increasing the amount of IT funding allocated to the VBMS program in FY 2016 by $60 million to support the specific IT enhancements.

CLAIMS REFORM MUST INCLUDE APPEALS REFORM

While the claims backlog has dropped significantly as indicated above, the backlog of pending appeals has risen over the past couple of years. Despite the fact that the Board completed more than 55,000 appellate decisions in FY 2014, an increase of 10 percent over the highest previous total, this improvement was primarily driven by an increase of more than 100 new FTEE. However, the number of appeals at various stages working their way through VBA toward the Board now tops 300,000. In order to address the pending workload in a reasonable timeframe, the Board will need to utilize a multi-pronged approach that includes increasing the size of staff, modernizing IT systems and innovative programs to streamline work.

One essential element needed to permanently address the backlog of pending appeals is to complete VBA's transformation and reform of the claims process. As the claims error rate goes down, and as confidence in the claims process grows, the percentage of claimants who later file appeals would be expected to fall. However, as VBA increases its productive capacity and the number of completed claims, an increase in the number of appeals could occur even if the accuracy rate continues to climb. Even accurate decisions may be appealed if they are unfavorable to claimants.

BOARD MUST INCREASE STAFFING TO MEETING RISING WORKLOAD

After several years of reduction in workforce, the Board has significantly increased its FTEE levels over the past three years, rising from an average of 510 FTEE in FY 2012 to an authorized level of 640 FTEE in FY 2015. Significant training and orientation are required for new Board attorneys to reach full productivity. The time taken away to train and mentor these attorneys reduces appeals output; therefore, some temporary losses in completed appeals may occur even with these new staff resources.

As indicated above, over the past five years the Board has averaged approximately 90 appeals dispositions per FTEE, producing a record 55,532 decisions in FY 2014. However, with the inventory of pending appeals now topping 360,000 in various stages at both VBA and the Board, there are simply not enough hands to do all the work that will be required, even with further efficiencies gained through technology and other reforms.

For FY 2016, the IBVSOs recommend an increase of 120 new FTEE, a 20 percent increase over the FY 2015 authorized level, which will require an additional $17 million.

THE BOARD'S IT NEEDS MUST BE ADDRESSED NOW

While VBMS for compensation claims processing has received virtually all of the IT attention and resources up to this point, the extension and adaptation of VBMS for the Board's use has been pushed back to future years due to limited budgets. While the Board has access to e-Folders to review claims records, the Board is unable to process appeals within a fully electronic environment. With the inventory of pending appeals at both VBA and the Board growing, IT modernization at the Board must move forward as a high priority.

The IBVSOs recommend that at least $15 million be allocated in FY 2016 for IT modernization to aid the Board.

VBA MUST STRENGTHEN THE DECISION REVIEW OFFICER PROGRAM

Another key approach to lowering the appeals workload for the Board is to strengthen the DRO post-determination review process, which can often be more effective or timely than the traditional appeals process because it resolves appellate-

related disputes at the VARO level. A DRO has de novo authority, meaning he or she reviews the entire appeal file with no deference given to the rating board decision. DROs can overturn or uphold a previous decision, hold hearings and perform any activity necessary to assemble evidence, including ordering medical examinations. Even if a DRO is unable to grant the benefit sought on appeal, any additional development work he or she performs could potentially shorten the time required by the Board to produce a decision.

For years, the IBVSOs have voiced concerns to VBA and Congress regarding the erosion of the DRO program. The number of DROs in the system is insufficient for the amount of DRO work generated in VAROs. Also the assignment of initial claims processing work to DROs at numerous VAROs further detracts from their intended work. Having DROs perform claims processing work when there is more than enough appeals work pending is merely shifting the weight of the backlog from one area to another. Over the past year VBA leadership has made some efforts to limit or eliminate the use of DROs in performing claims work; however, we continue to observe DROs at many VAROs working on claims processing activities. While we understand that VBA has limited resources but seemingly unending claims work, it is imperative that VBA ensure that DROs focus solely on appeals-related work. If additional personnel are required to process pending and future claims in a timely manner, VAROs must request additional resources, not repurpose DROs.

FULLY DEVELOPED APPEALS PILOT PROGRAM

In order to seek new solutions that could improve the appeals process for veterans, the IBVSOs, other VSO stakeholders, VBA and the Board worked to reach consensus on a new proposal to create a "fully developed appeals" (FDA) program modeled after the fully developed claims (FDC) program. The premise of the FDA program is that the appellant would assume responsibility for gathering all private evidence necessary for the appeal and agree to eliminate some steps and work required by VBA and the Board. In return the veteran would receive a significantly quicker appeal decision by the Board with no diminution in the quality or accuracy of that decision.

The FDA would become an additional option that the claimant could choose any time during the one-year period allowed to file an NOD. When veterans make the FDA election, they would be required to submit any and all additional evidence they want considered as part of their appeals and any arguments to support their appeals. They would also be required to certify that they have been fully informed about the FDA program, that they understand what they are required to do and not do, what VBA and the Board are required to do and not do, and that they consent to voluntarily filing their appeals in this manner. With this certification, the veterans' rating decisions and complete files—supplemented by any new evidence or argument submitted by veterans or their representatives at time of filing their FDA—would be transmitted directly to the Board and placed on a new FDA docket for date-ordered review and decision. Unlike the traditional appellate process, no Statement of the Case (SOC) would be created and issued, no VA Form 9 would be completed, no local VARO hearings or reviews would be conducted, no Board hearings would be held, no Supplemental Statement of the Case would be created, and no Form 8 certification process would occur. The elimination of these steps alone could save two to three years of processing at the VARO compared to a traditional appeals process.

Similar to the FDC program, the FDA program would require the veteran to certify that there is no additional private evidence relevant to the appeal under consideration, and if the veteran later submitted additional evidence after the date of filing, the appeal would revert from the FDA program and return to the traditional appeals process, without any loss of rights or options. The veteran could also withdraw his or her appeal from the FDA process at any time for any reason. The Board, however, would still be required to develop any Federal evidence, examinations or independent medical evaluations determined necessary for the Board to make its decision. The IBVSOs believe it is important that the FDA program be a time-limited, statutorily-authorized pilot program in order for VA to provide Congress and stakeholders the ability to oversee the program's design, implementation and operation, as well as to ensure that veterans' rights are fully protected.

It is important to understand that the FDA proposal is not a "magic bullet" that will eliminate the backlog of pending appeals; it is designed to be another option—one of many for veterans seeking to overturn an incorrect or unfavorable claims decision. As discussed above, the IBVSOs continue to strongly support the DRO process, and the FDA program is neither a substitute nor replacement for it. Instead, it will provide another option that each individual veteran and his or her represent-

ative, if any, can consider in making decisions about the most effective and timely process to resolve appeals.

RESOURCES FOR VOCATIONAL REHABILITATION AND EMPLOYMENT SERVICE

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 through five tracks: reemployment, rapid access to employment, self-employment, employment through long-term services, and independent living. Another key program helping to deliver VR&E assistance at a key transition point for veterans is the VetSuccess on Campus (VSOC) program which is operating at 94 college campuses. Additional VR&E services are provided at 71 military installations for active duty servicemembers undergoing medical separations through the Department of Defense's (DOD) and VA's joint Integrated Disability Evaluation System (IDES).

In order to meet the critical needs of veterans seeking employment, careers or more independent living, staffing levels throughout VR&E services must be commensurate with current and future demands. At the end of FY 2013, VR&E employed a total of 1,343 FTEE. VBA projected an increase in FY 2014 to an authorized level of 1,442 FTEE. In the FY 2015 budget request, VBA did not recommend increasing this staff and was again authorized 1,442 for FY 2015, despite an increasing workload.

In order for VR&E to keep pace with demand, the IBVSOs project the total number of VR&E participants at roughly 165,000 for FY 2016, nearly 10 percent in participant growth. At present there are roughly 974 VR&E counselors managing an active client caseload of roughly 140,000 participants which averages a counselor-to-client ratio of roughly 1 to 135. Ideally, a reasonable client-to-counselor ratio would consist of one VR&E counselor for every 125 veterans as has been advocated by the IBVSOs for the past several years. However, the average can be misleading as there are higher and lower actuals throughout VAROs. As an example, the Cleveland VARO's counselor to client ratio is 206 cases for every VR&E counselor, and in the Fargo VARO, 64 cases for each VR&E counselor. Therefore, it is essential that staffing increases be properly distributed throughout all of VR&E to ensure that counselors' caseloads are equitably balanced.

For FY 2016, the IBVSOs recommend an additional 382 FTEE, of which 277 would be dedicated as VR&E counselors and the remaining 105 employees dedicated to support services bringing VR&E's total FTEE strength to 1,824. The additional funding required for VR&E for FY 2016 would be $41.8 million.

OTHER PRIORITY BENEFIT PROPOSALS

Eliminate rounding down of veterans' and survivors' benefit payments

In 1990, Congress, in an omnibus reconciliation act, mandated veterans' and survivors' benefit payments be rounded down to the next lower whole dollar. While this policy was initially limited to a few years, Congress has continued to extend it every few years. Each year's

COLA is calculated on the rounded-down amount of the previous year's payments. While not significant in the short run, the cumulative effect over time results in a significant loss to beneficiaries.

The effect of rounding down monthly COLA increases has eroded approximately $10 per month for every veteran or survivor. For example, a veteran totally disabled from service-connected disabilities would have received $1,823 per month in 1994 and today will be paid at $2,848 per month. Had that veteran received the full COLA each year for the past two decades, he or she would receive about $120 extra this year, and cumulatively over two decades would have received almost $2,000 more. *The Independent Budget* veterans service organizations note and greatly appreciate that the most recent COLAs were not rounded down and urge Congress not to return to a policy of rounding down veterans' and survivors' benefits payments.

STRENGTHEN SUPPORT FOR SURVIVOR BENEFITS PROGRAMS

Increase DIC rates

The current rate of compensation paid to the survivors of deceased members is inadequate and inequitable when measured against other Federal programs. Under current law, DIC is paid to an eligible surviving spouse if the military servicemember died while on active duty or the veteran's death resulted from a service-related injury or disease.

DIC payments were intended to provide surviving spouses with the means to maintain some semblance of economic stability after the loss of their loved ones. All surviving spouses who rely solely on DIC, regardless of the status of their sponsors at the time of death, face the same financial hardships.

The IBVSOs recommend that the rate of DIC should be increased from 43 percent to 55 percent of a 100 percent disabled veteran's compensation for all eligible surviving spouses.

Eliminate DIC and SBP offsets

The current requirement that an annuity under the DOD SBP be reduced by an amount equal to DIC is inequitable because no duplication of benefits is involved. A veteran of military service is compensated for the effects of service-connected disability. When a veteran dies of service-connected causes or following a substantial period of total disability from service-connected causes, eligible survivors or dependents receive DIC from the VA.

Career members of the Armed Forces earn entitlement to retired pay after 20 or more years of service. Survivors of military retirees have no entitlement to any portion of the veteran's military retirement pay after his or her death, unlike many retirement plans in the private sector. Under the SBP, deductions are made from military pay to purchase a survivor's annuity. This benefit is not gratuitous but is purchased.

Upon a retiree's death, the SBP annuity is paid monthly to eligible beneficiaries. If the veteran died from other than service-connected causes or was not totally disabled by service-connected disability for the required time preceding death, beneficiaries receive full SBP payments. However, if the veteran's death was a result of military service or after the requisite period of total service-connected disability, the SBP annuity is reduced by an amount equal to the DIC payment. When the monthly DIC rate is equal to or greater than the monthly SBP annuity, beneficiaries lose the SBP annuity in its entirety.

The IBVSOs recommend that Congress repeal the inequitable offset between DIC and Survivor Benefit Plan (SBP) because no duplication occurs between these two separate and distinct benefits.

Allow remarriage after age 55

Current law allows retention of DIC upon remarriage at age 57 or older for eligible survivors of veterans who die on active duty or of a service-connected injury or illness. However, remarried survivors of retirees of the Civil Service Retirement System, for example, obtain a similar benefit at age 55. Equity with beneficiaries of other Federal programs should govern Congressional action for this deserving group, therefore Congress should lower the age required for remarriage for survivors of veterans who have died on active duty or from service-connected disabilities. This change in eligibility would also bring DIC in line with Survivor Benefit Plan rules that allow retention with remarriage at the age of 55.

Although the IBVSOs appreciate the action Congress took to allow restoration of this rightful benefit, the current age threshold of 57 years should be lowered to 55 for all eligible surviving spouses, consistent with other similar programs.

Mr. Chairman, that concludes our testimony and I will be happy to answer any questions from you or other members concerning these issues.

Chairman ISAKSON. Thank you very much.

Mr. Kelley.

STATEMENT OF RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. KELLEY. Mr. Chairman, on behalf of Veterans of Foreign Wars and our Auxiliaries, thank you for the opportunity to testify today. The VFW is responsible for the construction portion of the *IB*, so I will limit my remarks to that.

Gaps in access, utilization, and safety in VA's health care system's infrastructure exacerbated the conditions that lead to VA's unauthorized wait lists. VA currently sits at 119 percent capacity and admits they need $14 billion just to close current safety gaps. Every effort must be made to ensure these facilities remain safe

and sufficient environments to deliver care. To do this, large capital investments must be made.

Presenting a well-articulated, completely transparent capital asset plan, which VA has attempted to do, is important, but not adequately funding that plan will prevent VA from closing those current gaps and only cause them to grow.

Through Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress provided VA $5 billion to begin closing gaps in non-recurring maintenance and minor construction. However, this is a one-time infusion of funds, and it cannot be seen as a replacement for annual appropriations but, rather, an investment to reduce the backlog of safety and access gaps.

VA and Congress must develop a long-term funding strategy that addresses the four major components of capital infrastructure, which are non-recurring maintenance, major and minor construction, and leasing.

Non-recurring maintenance (NRM) projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors.

For buildings to last their life cycle, annual investments of non-recurring maintenance must occur. Over the past several years, VA has requested just over $700 million annually for NRM, barely half of what is needed to maintain facilities for their full life cycle.

The *IB* estimates VA needs to invest $1.35 billion annually in NRM as a baseline to ensure facilities are maintained in a safe and efficient manner. VA will need to invest additional funding to begin reducing the backlog of nearly 3,000 NRM projects.

There are currently 45 major construction projects that are partially funded dating back to fiscal year 2009. VA has also identified 114 major construction projects they determine will need to be completed within the next 10 years. While the *IB* is concerned about these future projects, the most pressing issue is finishing what they have already started.

Included in the 45 partially funded projects are 9 major construction seismic deficiencies. It will require $4.7 billion to close these safety gaps. VA must make efforts to close these deficiencies in these properties.

The *IB* recommends that Congress appropriate $1.9 billion for fiscal year 2016 to set VA on a course to close all currently partially funded projects and begin funding the remaining seismic deficiencies within the next 5 years.

VA has come close to keeping up with its minor construction needs over the past few years. It is estimated that to close all minor construction gaps that have been identified, VA will need to invest between $7 billion and $9 billion over the next 10 years. Along with the funds that have been authorized for minor construction projects over the next 2 years through VACAA, the *IB* recommends an additional $575 million for fiscal year 2016.

VA's capital leasing program allows VA to improve veterans' access to health care by entering into multiyear leases that provide the Department flexibility to increase and decrease the size and scope of care that is delivered in more than 800 communities. Thanks to the passage of VACAA, 27 major medical leases have been authorized. While funding these leases is a step in the right

direction, it will be nearly 2 more years before the medical facilities see patients because of delays in funding and the current contract authorization process.

Congress and VA must find a long-term solution to authorize these leases so they can be funded quickly and contracts can be filled without delay, so veterans do not wait years for these facilities to be completed.

Mr. Chairman, this concludes my testimony, and I look forward to any questions you or the Committee may have.

[The prepared statement of Mr. Kelley follows:]

PREPARED STATEMENT OF RAYMOND C. KELLEY, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee, on behalf of the nearly 1.9 million members of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, thank you for the opportunity to testify before you today regarding the Department of Veterans Affairs (VA) Fiscal Year (FY) 2016 budget recommendations. The VFW works alongside the other members of the *Independent Budget* (*IB*)—AMVETS, Disabled American Veterans and Paralyzed Veterans of America—to produce a set of policy and budget recommendations that reflect what we believe would meet the needs of America's veterans. The VFW is responsible for the construction portion of the *IB*, so I will limit my remarks to that portion of the budget.

Gaps in access, utilization and safety in VA's heath care system's infrastructure exacerbated the conditions that lead to VA's unauthorized wait lists, causing veterans to wait too long to receive the care they need and deserve. VA currently sits at 119 percent capacity and admits to needing $14 billion just to close current safety gaps.[1] Every effort must be made to ensure these facilities remain safe and sufficient environments to deliver care. A VA budget that does not adequately fund facility maintenance and construction projects will continue to reduce the timeliness and quality of care for veterans.

The vastness of VA's capital infrastructure is rarely fully visualized or understood. VA currently manages and maintains more than 6,000 buildings and almost 34,000 acres of land with a plant replacement value (PRV) of approximately $90 billion. Although VA has decreased the number of critical infrastructure gaps, there remain more than 4,000 gaps that will cost between $56 and $68 billion to close, including $10 billion in activation costs.[2]

Quality, accessible health care continues to be the focus of the *Independent Budget* Veterans Service Organizations (IBVSOs), and to achieve and sustain that goal, large capital investments must be made. Presenting a well-articulated, completely transparent capital-asset plan, which VA has attempted to do, is important, but not adequately funding that plan will prevent VA from closing current access, utilization and safety gaps and only cause those gaps to grow.

In August of last year, Congress provided VA $5 billion to begin closing access gaps, by including funding for non-recurring maintenance (NRM) and minor construction projects when it passed the Veterans Access, Choice, and Accountability Act of 2014 (VACAA). VA has identified approximately 400 minor and NRM projects that this funding will complete, ensuring facilities are maintained and existing facilities last for their projected life-cycle. However, this one-time infusion of funds cannot be seen as a replacement for annual appropriations, but rather an investment to reduce the backlog of safety and access gaps.

VA and Congress must develop a long-term funding strategy that addresses the four major components of capital infrastructure: non-recurring maintenance, major construction, minor construction, and leasing.

NON-RECURRING MAINTENANCE ACCOUNTS

Even though non-recurring maintenance is funded through VA's Medical Facilities account and not through the construction account, it is critical to VA's capital infrastructure. NRM embodies the many small projects that together provide for the

[1] Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 10.3–12, 9.3–11.

[2] Department of Veterans Affairs, FY 2015 Budget Submission Construction and 10 year Capital Plan, Vol. 4 of 4, February 2014, p. 1–4, 9.2–7.

long-term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors, among other routine maintenance needs. Non-recurring maintenance is a necessary component of the care and stewardship of a facility. When managed responsibly, these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

To maintain existing infrastructure, annual investments in non-recurring maintenance must occur to ensure the building will last for its projected life-cycle. Over the past several years, VA has requested just more than $700 million for NRM, barely half of what is needed to maintain facilities for their full life-cycle.

The IBVSOs estimate VA needs to invest $1.35 billion annually in NRM as a baseline to ensure facilities are maintained in safe and efficient manner. VA will need to invest additional funding to begin reducing the backlog of nearly 3,000 NRM projects.

MAJOR CONSTRUCTION ACCOUNTS

There are currently 45 major construction projects that are partially funded dating back to FY 2009. VA has also identified 114 major construction projects they determine will need to be completed within the next 10 years to close gaps in veterans' access to care. While the IBVSOs are concerned with these future projects, the most pressing issue is finishing what has already been started.

Included in the 45 partially funded projects are nine major construction seismic deficiencies. There are also four other seismic projects that have not been funded at all. It will require $4.7 billion to close these safety gaps. VA must make correcting these deficiencies a priority and provide a plan to achieve these goals.

The IBVSOs recommend that Congress appropriate $1.9 billion in FY 2016 to set VA on a course to close all currently partially funded projects and begin funding the remaining seismic deficiencies within the next five years.

MINOR CONSTRUCTION ACCOUNTS

VA has come close to keeping up with its minor construction needs over the past few years. It is estimated that to close all minor construction gaps that have been identified, VA will need to invest between $7 billion and $9 billion. Along with the funds that have been authorized for VA's minor construction projects over the next two years through VACAA, the IBVSOs recommend an additional $575 million for FY 2016 to ensure VA stays on track to close all its current and future minor construction gaps.

CAPITAL LEASING ACCOUNTS

VA's capital leasing program allows VA to improve veterans' access to health care by entering into multiyear leases that provide the Department flexibility to increase and decrease the size and scope of care that is delivered in more than 800 communities. Thanks to the passage of VACAA, 27 major medical leases have been authorized. While funding these leases is a step in the right direction, it will be nearly two more years before these medical facilities see patients, because of delays in funding and the current contract authorization process.

Congress and VA must fund a long-term solution to authorize leases so they can be funded quickly and contracts can be filled without delay, so veterans do not wait years for these facilities to be completed.

In conclusion, the Department of Veterans Affairs has improved its capital infrastructure gap analysis through its Strategic Capital Investment Planning (SCIP) process, but they have continually fallen short of requesting the funds necessary to close these gaps and Congress continues to appropriate the amount VA requests. VA must present a long-term management plan than will connect the SCIP gap analysis with appropriate funding requests that will design, build and activate each project on time and on budget so access, utilization and safety gaps are closed quickly and veterans can receive timely, quality access to health care.

Mr. Chairman, this concludes my testimony, and I am prepared to answer any questions you or the Committee members may have.

Chairman ISAKSON. Thank you very much, Mr. Kelley.

Mr. de Planque.

STATEMENT OF IAN DE PLANQUE, DIRECTOR, NATIONAL LEGISLATIVE DIVISION, THE AMERICAN LEGION

Mr. DE PLANQUE. Good morning, Mr. Chairman. I want to extend special thanks to you for taking the time not only to sit down with our Commander after hearing our Commander's testimony, but also to come out and address the members of our organization and give them a little bit of your vision for how this country can serve veterans in the 114th Congress and beyond.

On behalf of that Commander, Commander Mike Helm, and the 2.3 million veterans who make The American Legion the largest wartime veterans service organization, I appreciate the opportunity to testify before you today.

I think everyone agrees our country has a responsibility to make good on the promises we make to those who have defended the Nation, but the country is a lot more than the budget of a single agency or the people of a single agency. Taking care of veterans requires efforts from all of us—VA, veterans, Congress, every single stakeholder.

The past year brought hard truths to light. VA has struggled to come to terms with admitting there were problems with veterans' ability to access care. We needed to bring those problems to the light to address them, and we have begun to address them, but it is going to take more time and complete transparency.

We are happy to see that VA has chosen to address shortfalls in full-time workers and employees at the VBA. They are requesting an additional 770 workers to address claims. Regardless of whether the VBA eliminates the backlog this year or any other year, it is quite clear that additional help is needed. VBA workers have been working under mandatory overtime policies for over 4 years now. Overtime for a few weeks is indicative of a problem that needs a surge of assistance. Overtime for 4 years is a big indicator you just do not have the bodies to get the job done.

To be fair, more studies and a clearer picture of the resource allocation would be helpful, especially for future planning to determine whether VA needs help long in advance of future backlogs. It is clear to everyone involved that VBA needs help to help veterans with their claims, and The American Legion strongly supports ensuring that they get the workers that they need.

We were especially encouraged speaking with VBA officials to hear they anticipate boosting employees at the decision review officer level. Decision review officers have experience and skills to resolve appeals more quickly at the regional office before an appeal can begin a multiyear journey at the Board of Veterans Appeals. Sadly, for the past few years, we have seen firsthand in multiple offices that these decision review officers have been pushed into other tasks and their important work on appeals is falling by the wayside. Hopefully this indicates a new commitment to solving problems at the regional office level, fixing veterans' claims before they descend into the lengthy appeals process.

American Legion members are dedicated to making the VA a better place. Last year, over 7,000 American Legion members contributed over 900,000 hours of community volunteer service to the VA through the Veterans Affairs Voluntary Service (VAVS) program, supported by The Legion since 1946. I know all of our colleagues

here at the table and their organizations make time and contributions as well. The cost savings to the VA is immeasurable, and the key point here is we are all invested in this. We all have skin in this game. We are all working to do this. But to make sure we put those resources in the right place, we need to all communicate openly, honestly, and completely transparently with one another. This only works when we are all on the same page. We stress again the importance of a publicly open and transparent planning process for all stakeholders to work together to maximize what funds are available and to make the system work for all veterans. This only works when we all work together.

I would be happy to take questions, though I first want to comment also specifically on what my colleague, Mr. Blake from Paralyzed Veterans of America, has discussed about the Choice Act and trying to make sure we get to those veterans within the 40-mile area. Just in January, I went out to Kansas myself to speak with American Legion members there, and I could see firsthand there are still a lot of problems. The numbers may have been astronomically high with the initial assessments in the budget, but we are seeing almost microscopically low numbers of people choosing to use that right now. And I think when we field calls, when we talk to veterans in The American Legion—and we have talked to a lot of them—many of them are confused and are having trouble accessing it because it is not being very well explained to them. They do not really understand why, if there is a facility 38 miles from them but they still have to go 250 miles to get the treatment that they need—maybe it is dialysis, maybe it is heart treatment—why they are not eligible for that program.

When we spoke with Senator Blumenthal, the Ranking Member, in his office yesterday, one of the things he talked about was the intent of the program. I know the language of the bill is very specific, and I know that that was perhaps an attempt to address some of the concerns of the Congressional Budget Office. But, we are interested in continuing to work with Members of the Committee to make sure that veterans are getting access.

The reason we came up with this was choice, and it is a choice. Not every veteran is going to choose to use it. Many of the veterans are going to choose to wait longer. But the ones who want to get into that care and who need the access—there are many ways VA has in the past used outside care, whether it is PC3 or ARCH or other programs. Choice is another tool that can help get those veterans into care, and we want to make sure that it is implemented within the intent of the Committee and the intent of the veterans service organizations who supported it, which is to get those veterans access to care.

Thank you.

[The prepared statement of Mr. de Planque follows:]

PREPARED STATEMENT OF IAN DE PLANQUE, DIRECTOR, NATIONAL LEGISLATIVE DIVISION, THE AMERICAN LEGION

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee: On behalf of National Commander Michael Helm and the 2.3 million wartime veterans of The American Legion, we welcome this opportunity to comment on the Federal budget, and specific funding programs of the Department of Veterans Affairs (VA).

The American Legion is a resolution based organization; we are directed and driven by the millions of active legionnaires who have dedicated their money, time, and resources to the continued service of veterans and their families. Our positions are guided by nearly 100 years of consistent advocacy and resolutions that originate at the grassroots level of the organization—the local American Legion posts and veterans in every congressional district of America. The Headquarters staff of the Legion works daily on behalf of veterans, military personnel and our communities through roughly 20 national programs, and hundreds of outreach programs led by our posts across the country.

The American Legion comes before this Committee in a unique state of military affairs, as for the first time in over a decade, this country is not officially engaged in combat operations in Afghanistan or Iraq. Though combat operations in Afghanistan may have officially ceased on December 28, 2014, there is no doubt the effects of these wars will continue to be felt in the veterans' communities for many decades, as has been the case with every previous war. The cost of war does not end when the guns fall silent. To paraphrase Winston Churchill this is not the beginning of the end, but rather the end of the beginning.

We cannot allow focus and resources to be diverted from the VA because the limelight fades and the news cameras have gone away. The President's proposed budget would offer an increase of 7.5 percent over the enacted level of Fiscal Year 2015 funding, a healthy increase even as other agencies are forced to tighten belts under the effects of sequestration. However, we cannot think that just because the numbers go up that all of the money is being directed to the proper places. Here is where the importance of true transparency from VA becomes critical. This is where the importance of open and freely available planning reports, such as those proposed in the "Department of Veterans Affairs Budget Reform Planning Act of 2015." (H.R. 216) This legislation, recently recommended out of Committee in the House Committee on Veterans Affairs, would be helpful to the entire community of stakeholders. Many of the questions we will raise delve into matters that would be more clear if VA was more open and straightforward with stakeholders.

This process only works if everyone can see all the pieces on the board. Taking care of veterans is the Nation's responsibility. That includes not only the Federal Government, but state and county governments, veteran and military service organizations, and the citizens themselves. We have to all see how the pieces fit together and we have to all be on the same page if this is going to work and we're all going to maximize our efforts together.

There are areas of concern within the budget proposed by VA, but all of these areas can be worked out if everyone is open and above board.

THE VETERANS BENEFITS ADMINISTRATION

This year, 2015, is to be the year the Veterans Benefits Administration finally "breaks the back of the backlog." To that end, the budget request includes requests to add 770 additional full time employees (FTEs) as claims processing workers and fiduciaries for the pension program. Adding additional workers is an important and needed step. VA employees have been directed to put in mandatory overtime work dating back to at least 2011.[1] Mandatory overtime may provide a useful boost to push an organization through a tough patch, but four straight years of mandatory overtime indicates an organization that's not going through a tough patch, it's an organization that's clearly understaffed.

How many additional employees are appropriate? This is where it's difficult to tell and where a study of VA's resource allocation models would be helpful. At VA's budget roll out, VA officials indicated some of this would be represented in making the Decision Review Officer (DRO) process more robust, something The American Legion strongly supports. DROs can often resolve appeals more rapidly than the appeal process at the Board of Veterans Appeals (BVA) and with greater accuracy and clarity than the average VA rater. Reports have indicated in some offices the DROs have been reassigned to other tasks as the pressure mounts to work on initial claims. It would be the hope of The American Legion that renewed interest in hiring and increasing the DRO force would allow DROs to return to their appeals duties, and help prevent a rising backlog in the appeals area.

Whatever the case may be, better communication from VA to indicate how they intend to use staffing levels to effectively combat the backlog of claims is a must.

The American Legion strongly supports additional FTEs to improve the VBA workforce.

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[1] http://www.stripes.com/va-workers-say-mandatory-overtime-won-t-solve-benefits-backlog-1.221294

THE VETERANS HEALTH ADMINISTRATION

One of the key lessons learned through last year's health care access is that VA's reporting must be crystal clear to avoid the problems that occur when things are hidden from the stakeholders. Had VA employees not manipulated the wait time data a more bleak picture of the ability to serve veterans would have been painted, but the key stakeholders—veterans and Congress—would have known that additional resources were needed and where. Ensuring proper distribution of resources throughout VA depends on accurate reporting that is free from fear of reprisal for not meeting goals. We cannot create an environment where VA employees fear to report problem areas, for discerning where those problem areas are occurring is the critical factor in determining where resources need to go.

To be fair, Secretary McDonald has expressed a renewed interest in openness and The American Legion believes VA is making a good faith effort to increase honesty, although we would like more clarity regarding the Secretary's request for more flexibility in use of the funds designated for the Choice card program. VA's budget request announces that they will be seeking more flexibility to retarget some of the $10 billion allotted to the Choice card program with last year's legislation to provide more choice and access in care.

Without an extremely specific accounting, which was not forthcoming in initial presentations of this budget, it would be difficult to support this request. The Choice program, which The American Legion believes is an important temporary measure to address shortfalls in VA's ability to treat veterans, needs to be properly funded to succeed. To reprogram monies designated for this program so early into the program, barely six months into a three year pilot, seems short sighted. It would be the preference of The American Legion to see the program implemented as intended, and if funds remain at the end of the allotted time, then it would be appropriate to address what use those funds could best be put to. If there is money left over, great; that would mean VA was meeting their goal of addressing veterans' needs with their in house resources, to include VA care as well as other assets in their arsenal such as the PC3 program or ARCH, the very successful rural health initiative.

Regarding other important VHA funding, The American Legion notes that VA's budget for medical research is relatively consistent, but positively notes the acknowledgement of the importance of additional areas of Posttraumatic Stress Disorder (PTSD) research including alternative therapies such as yoga, meditation and other treatments alongside cognitive processing therapy (CPT) and prolonged exposure therapy. The American Legion continues to devote extensive focus to the treatment of PTSD and Traumatic Brain Injury (TBI) through the PTSD and TBI Committee of the Veterans Affairs and Rehabilitation (VA&R) Commission. The Commission's work included the production of "The War Within" and a survey conducted in conjunction with the Data Recognition Corporation which presented results last year at a June 24th symposium entitled "Advancing Care and Treatment for Veterans with TBI and PTSD."[2] [3] Through that survey, it was reported that nearly 60% of veterans undergoing treatment for PTSD and TBI reported feeling no improvement or felt worse after the traditional treatments.[4] Clearly, there is still much room for improvement in this area.

The American Legion supports VA becoming a robust leader in complementary and alternative medicine for Posttraumatic Stress Disorder and Traumatic Brain Injury.

CONSTRUCTION AND FACILITIES

All stakeholders are aware of the much publicized struggles VA has gone through with major construction projects, particularly in Colorado, Florida, Louisiana and Nevada. VA recently came to an agreement with the contracting firm in Colorado and work was able to resume on the VA hospital project in Aurora. That work will likely cost at least $234 million, and the budget for the project has spiraled from approximately $600 million to over $1 billion.[5] The money for these overages has to come out of VA's construction budget, yet where the money to backfill that budget and provide for future projects will come from is still unclear.

In February 2012, The American Legion presented the following warning about insufficient funding in VA's construction budgets and capital investment plans:

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[2] http://www.legion.org/sites/legion.org/files/legion/publications/war-within.pdf
[3] http://www.legion.org/veteranshealthcare/222891/legion-survey-ptsdtbi-care-not-working
[4] http://www.legion.org/veteranshealthcare/222891/legion-survey-ptsdtbi-care-not-working
[5] http://kdvr.com/2014/12/17/va-announces-deal-to-start-work-on-aurora-hospital/

The SCIP planning process develops data for VA's annual budget requests. These infrastructure budget requests are divided into several VA accounts: Major Construction, Minor Construction, Non-Recurring Maintenance (NRM), Enhanced-Use Leasing, Sharing, and Other Investments and Disposal. The Fiscal Year (FY) 2012 VA budget identified more than 5,000 capital projects needed to close all the identified infrastructure gaps over the ten year period. The VA estimated costs were between $53 and $65 billion.

The American Legion is very concerned about the lack of funding in the Major and Minor Construction accounts. In FY 2012 The American Legion recommended to Congress that the Major Construction account be funded at $1.2 billion and the Minor Construction account be funded at $800 million. However, Congress only appropriated $589 million and $482 million respectively to those accounts. Based on VA's SCIP plan, Congress underfunded these accounts by approximately $4 billion in FY 2012. Clearly, if this underfunding continues VA will never fix its identified deficiencies within its ten-year plan. Indeed, at current rates, it will take VA almost sixty years to address these current deficiencies.[6]

Even before the setbacks in Colorado and Florida created holes in the construction budgets, there were already grave concerns about the ability to meet the needs that had been identified. Now that the struggling major projects are depleting funds at a greater rate than previously anticipated, the danger to future projects is even more severe.

The American Legion urges Congress and VA to get on the same page about fixing these budget holes before it's too late. We must act now. Whether this will require supplemental appropriations to make the troubled major construction projects whole again without jeopardizing the rest of VA's construction needs, or whether this can be built into the budget is still a topic for discussion. What is clear is that this is going to present a major hurdle to ensuring VA's facilities are able to handle the load. This is a problem that needs a solution.

The hospitals are not the only area of concern in terms of facilities. Last year's Veterans Access, Choice and Accountability Act (VACA) provided a respite for 27 Community Based Outreach Centers (CBOCs). The CBOCs have been an effective tool in reaching veterans, particularly in rural areas where a full scale hospital might not be feasible. Changes in how the leases for these facilities were scored by the Congressional Budget Office (CBO) jeopardized the future of CBOCs within the VHA health care system.

VACA provided relief for the 27 identified CBOCs, but in a sense it has only kicked the can a little further down the road. A long term solution to the CBOC lease conundrum will be required.

The American Legion urges Congress to provide an annual or permanent exemption for the Department of Veterans Affairs leases from the Congressional Budget Office's scoring process, so as to give VA the flexibility it needs to meet the health care needs of veterans.[7]

CONCLUSION

The past year has made it clear that VA cannot afford to be run as an entity reactive to one crisis after another. Effectiveness stems from long term planning, and to be truly effective that long term planning needs to include all stakeholders. The American Legion has been a strong and active supporter of the Department of Veterans Affairs Voluntary Service (VAVS) since 1946 and today over 7,000 volunteers provide 900,000 hours of volunteer service at VA medical centers, CBOCs, Vet Centers, state veterans' homes, and nursing homes every year.[8] With nearly a million hours of service provided, imagine the cost savings to VA in terms of additional FTEs they do not have to provide.

That kind of coordination only works with open transparency. The American Legion urges VA to adopt an open and freely accessible planning process such as the quadrennial review proposed in H.R. 216 and endorsed by many members on both sides of the aisle in the House of Representatives. We would be happy to see the Senate take up legislation of this type to ensure VA's planning process is robust, includes all stakeholders, and is transparent to allow input and analysis from all concerned parties.

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[6] American Legion testimony before HVAC on the VA Budget, February 15, 2012

[7] Resolution 282: Congressional Budget Office Scoring on Department of Veterans Affairs Leasing—AUG 2014

[8] http://www.legion.org/vavolunteers

Secretary McDonald has a daunting task ahead of him as he continues to reform the VA and rebuild from the failures that led to last year's crises. There is no reason to go it alone. Congress has long displayed a willingness to provide VA with resources, increasing their budget nearly 75 percent since 2009 alone, and The American Legion has already gone out and conducted a dozen Veterans Crisis Centers and Veterans Benefits Centers in the field to help link VA and veterans up to make the system work. To be truly effective though, we all have to be reading from the same page. This is something that can and will be accomplished, and The American Legion looks forward to making that happen.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861–2700, or ideplanque@legion.org.

Chairman ISAKSON. Thank you very much for your testimony, and you are right on point regarding Choice.

Vietnam Veterans of America.

STATEMENT OF RICHARD WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Mr. WEIDMAN. Mr. Chairman, thank you for the opportunity for VVA to present our testimony here today.

Our estimate for VHA only is that $71 billion is needed for this coming fiscal year and 74 for the advanced appropriations. We have come at it from a different direction that is much more—takes into account that each veteran has many more presentations, or things wrong with them, than the civilian formula allows for. The formula that they use now is set up on one to three presentations. Why? Because it was designed for PPOs and HMOs and people who can afford to buy those kinds of plans. That, by and large, is not necessarily who we see at VA hospitals.

In regard to the wait times, I just wanted to give some perspective here. In 2009, VVA testified before the Congress in regard to the budget, "We are more than a little skeptical that, as the VA touts, the budget will provide resources to virtually eliminate the patient waiting time by the end of 2009." That was 5 years ago, and they are still struggling with it. If the formula is not working to tell you how many clinicians you need, then you need to get a new formula, as well as management improvements.

There are a couple of things I want to mention about the Choice Card. VVA has always backed using fee-basis options when it is a service that is available in the community and it is otherwise a long commute for the veteran. But, the reason why—I know the Secretary in his motivation, which is a laudable one, to have a lot of flexibility in all of the fundings, but I will tell you right now, if the Vet Centers had not had fenced funding, they would not have been there when the OEF/OIF/OND veterans came home. They would have gone, poof, up in smoke.

Recently, the QUERI groups around the country—those are groups of clinicians who come up with the best practices and come up with the best medicine or, excuse me, best evidence-based medicine recommendations—all of their funding got swept clean. A little bit of it was restored, but if you do not have QUERI groups, you do not have evidence-based medical practice. So, the reason for that is why the fences came up, because things went awry at VA over time.

Another example is Hepatitis C. There are 175,000 veterans within the VA system who have tested positive and we finally have

a cure. We finally know who they are and can move forward. But, one of the reasons it has taken so long to get to that point is every time that Congress gave fenced-off money to the VA to address the problem of Hepatitis C, nobody could account for the money, and we think that is crazy.

There are two things that really need to happen, and when I say that we want strings on the appropriations, it is: one, that they be able to tell you how many clinicians do they have in Dublin, GA, who deal with PTSD and TBI at any given time without having to send somebody out there to count; and, two, that you know exactly what is happening, that they start tracking veterans so you know what treatment modality is most effective. All of those kinds of accountability mechanisms are still lacking in the VA and need to get fixed.

Another example of something that needs real attention. The National Vietnam Veterans Longitudinal Study, which was a replication of the original study done in the mid-1980s, the National Vietnam Veterans Readjustment Act, is finally done. It was delivered to the VA Central Office in September 2014 and it still has not reached the Congress. And, the reason is, quote-unquote, a "legal problem" the General Counsel has because they want to order the contractors to destroy the data of the original study back in 1985. Had that been done—which they wanted to do after the first one—there could not have been a replication.

So, it is that kind of accountability that we need to bring in and have a central place for a repository of data that everybody trusts. We have such a thing. It was started after World War II by General DeBakey, Dr. Roger [sic] DeBakey, and its medical follow-up agency was part of the Institute of Medicine of the National Academies of Sciences. We recommend, one, that all things be turned over to them, whether ranchhand information or the National Vietnam Veterans Longitudinal Study, and, two, that VA set aside $4 million per year for maintaining that data and cataloging it in modern computer language.

Mr. Chairman, I thank you very much for the opportunity to present here today.

[The prepared statement of Mr. Weidman follows:]

PREPARED STATEMENT OF RICHARD WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Chairman Isakson, Ranking Member Blumenthal and distinguished Members of the Committee: On behalf of the Board of Directors, and members, I thank you for giving Vietnam Veterans of America (VVA) the opportunity to testify today regarding the President's fiscal year 2016 budget and 2017 advanced appropriations request for the Department of Veterans Affairs. VVA thanks each of you on this distinguished panel, on both sides of the aisle, for your strong leadership on issues and concerns of vital concern to veterans and their families.

I want to thank you for recognizing that caring for those who have donned the uniform in our name is part of the continuing cost of the national defense. Caring for veterans, the essential role of the VA and, for specific services other Federal entities such as the Department of Labor, the Small Business Administration, and the Department of Health and Human Services, must be a national priority. This is poignantly clear when we visit the combat-wounded and ill troops at military medical centers across the country.

OVERVIEW

On the whole, this budget proposal is a good start, but the overall requests for additional resources are just too low. With concerted work however it can be the most viable budget and appropriations document we have had in many years, of which we all can be proud.

VVA is still concerned that there will not be enough resources to deal with the flood of troops that continue to separate and have recently separated from the military and may present at VA with a range of mental health as well as TBI and other physiological health issues. The newer veterans, and the older "new to VA" veterans from previous generations who are now using VA healthcare facilities and services added to a volume of needs that was already taxing VA resources. This set up the conditions whereby there were way too few clinicians for increasingly too many clinical needs, which put pressure all the way down the line to not have delays in seeing sick veterans. Because they did not have the organizational capacity to do this, then the local staff got into the business of making it appear that there were no wait lists.

We do not say this in any way of excusing the lying and the falsification of data. There is no excuse for that. However, if the problem is to be fixed, then there simply needs to be a sharp increase in the number of clinicians at VA, and a priority put on providing enough appropriate clinical space at the earliest possible date. What this means is that there must be construction funds for converting what exists in the VA's older hospitals to accommodate a modern clinic configuration. If they need to move executive and other offices to temporary buildings outside of the main hospital building (s) in order to have enough room, then let us get on with it.

While many do not like to focus on the fact that there are way too few clinicians, that is the case now, as it has been for more than a decade. As one example VVA said in testimony in 2009:

> We are more than a little skeptical that, as the VA touts, the budget will provide resources "to virtually eliminate the patient waiting list by the end of 2009." When have we heard this before?

The "wait list" on the medical side, and the "backlog" on the Compensation and Pension side of VA simply have to have more resources (mostly people) if these problems are to be solved.

To us the key is to modify the formula that is used to estimate clinical needs to reflect the veterans who are served. The number of disability issues to be adjudicated in each claim has risen dramatically in the last five years, even faster that the number of veterans seeking both medical care and adjudication of legitimate claims. That is mirrored in the sharp rise in the number of maladies in veterans seeking medical care

Our recommendation is to change the formula to reflect reality of veteran's health, and in the meantime fund VHA for at least $71 Billion this year and Advance Appropriations for at least $74 Billion, with at least $3 to 3.5 Billion in third-party medical care collections each year. Even this estimate is likely an understatement of the need.

EVIDENCE BASED MEDICINE

VA has a well-established system of "QUERI" groups that have functioned reasonably well for some years to establish a baseline for evidence based medicine within the VA. The budgets for these groups were recently "swept away" by the Secretary. If there are efforts to reorganize and improve this vital tool, then fine. But to virtually cripple or to outright de-fund the QUERI groups signifies that VA is going to not have a mechanism to know the standards for evidence based medicine.

This situation needs to be corrected immediately and certainly in the budget for the coming year.

MENTAL HEALTH—NEED TO INCREASE ORGANIZATIONAL CAPACITY FOR SUBSTANCE ABUSE TREATMENT

VVA urges that language be inserted in the Appropriations bill before Congress to express concern that substance abuse disorders among our Nation's veterans are not being adequately addressed by the Veterans Health Administration (VHA). The relatively high rate of drug and alcohol abuse among our Nation's veterans (much of which is self-medication to deal with untreated PTSD), especially those returned from service in Operations Enduring Freedom, Iraqi Freedom, and New Dawn is causing significant human suffering for veterans and their families.

These folks can and will be stronger for their experience if we only will deliver the effective care they need when they need it in a way they will accept.

Further delay in moving to increase effective mental health and substance abuse services will lead to poorer health and more acute health care utilization in the out years, not to mention economic opportunity cost to the Nation and needless suffering by these veterans, and their families.

VVA urges the Congress to direct the Secretary to provide quarterly reports beginning with a baseline report by each Veterans Integrated Service Network (VISN) and each VA Medical Center (VAMC) on the number and type of clinicians engaged in mental health, especially those engaged in treating PTSD and substance abuse.

VVA also strongly urges the Senate to direct the Secretary of Veterans Affairs to update the VHA Strategic Plan for Mental Health Services, specifically to improve VA's treatment of TBI, PTSD and other mental health conditions, as well as substance use disorders. These reports will provide an ongoing indication of VHA's progress in the implementation of its adopted Strategic Plan as described in section 1.2.8 of "A Comprehensive VHA Strategic Plan of Mental Health Services," May 2, 2005. In addition to baseline information, at minimum these reports should include: the current ranking of networks on their percentage of substance abuse treatment capacity along with plans developed by the lowest quartile of networks to bring their percentage up to the national average; and, the locations of VA facilities that provide five days or more of inpatient/residential detoxification services, either on site, at a nearby VA facility, or at a facility under contract to provide such care; and, the locations of VA health care facilities without specialized substance use disorder providers on staff, with a statement of intentions by each such facility director of plans to employ such providers or take other actions to provide such specialized care.

We must continue to restore and enhance capacity to deal with mental disorders, particularly with Post Traumatic stress Disorder and the often attendant co-morbidity of substance abuse. In particular, substance abuse treatment needs to be expanded greatly, and be more reliant on evidence based medicine and practices that are shown to actually be fruitful, and be held to much higher standards of accountability, as noted above. The 21 day revolving door or the old substance abuse wards is not something we should return to, but rather treatment modalities that can be proven to work, and restore veterans of working age to the point where they can obtain and sustain meaningful employment at a living wage, and therefore re-establish their sense of self-esteem.

NATIONAL CENTERS FOR PTSD

VVA also urges that additional resources explicitly be directed in the appropriation for FY 2016 to the National Centers for PTSD for them to add to their organizational capacity under the current fine leadership. The signature wounds of the recently completed wars are PTSD and Traumatic Brain Injury and a complicated amalgam of both conditions. VVA believes that if we provide enough resources, and hold VA managers accountable for how well those resources are applied, that these fine young veterans suffering these wounds can become well enough again to lead a happy and productive life.

SEPARATE FUNDING LINE FOR THE VET CENTERS

The funds for the Vet Centers should be used to develop or augment permanent credentialed staff at VA Vet Centers (Readjustment Counseling Service or RCS), as well as coordinating with the PTSD teams and substance use disorder programs at VA medical centers and clinician who are skilled in treating both PTSD and substance abuse at the CBOC, which will be sought after as more troops (Including demobilized National Guard and Reserve members) return from ongoing deployments.

VA also urges that the Secretary be required to work much more closely with the Secretary of Health and Human Services, and the states, to provide counseling to the whole family of those returning from combat deployments by means of utilizing the community mental health centers that dot the Nation. Promising work is now going on in Connecticut in and possibly elsewhere in this regard that could possibly be a model. In addition, VA should be augmenting its nursing home beds and community resources for long term care, particularly at the state veterans' homes.

BLIND AND LOW VISION VETERANS NEED MUCH GREATER RESOURCES AND ATTENTION

With the number of blind and very low vision veterans of the Nation's latest wars in need of services now, VVA strongly recommends the Congress explicitly direct an additional $50 million for FY 2016 to increase staffing and programming at the VA's

Blind and Visually Impaired Service (VIST) Centers, and to add at least one new center.

Further, VVA recommends that the Congress direct the Secretary to implement an employment and independent living project modeled on the highly successful "Project Amer-I-Can" that so successfully placed blind and visually impaired veterans into work and other situations that resulted in them becoming much more autonomous and independent. That program was a cooperative venture of the New York State Department of Labor, the Veterans Employment & Training Service (VETS), and the Blind Veterans Association twenty years ago, but can still work now.

MEDICAL AND PROSTHETIC RESEARCH

For medical and prosthetic research for fiscal year 2016, VVA recommends $950 million. This would be the largest increase ever in this part of the budget, but it is needed and should be "with strings" that the VA start doing research that will stand up to peer review in regard to toxins of all sorts that have affected US military members and/or their families, especially their progeny.

VA's research program is distinct from that of the National Institutes of Health because it was created to respond to the unique medical needs of veterans. In this regard, it should seek to fund veterans' pressing needs for breakthroughs in addressing environmental hazard exposures, post-deployment mental health, Traumatic Brain Injury, long-term care service delivery, and prosthetics to meet the multiple needs of the latest generation of combat-wounded veterans.

NVVLS

The *National Vietnam Veterans Longitudinal Study* (NVVLS) has been completed at long last, and languishes at the VA Central office. The General Counsel at VA says there is a "legal problem" with transmitting this report to the Congress and the public. The so called legal problem is that VA wants to destroy all of the data in the original National Vietnam Veteran Readjustment Study (NVVRS). The VA General Counsel first wanted to destroy that data right after that study was first completed in the mid-1980s. Had they done so, there could never have been this follow up study.

VVA urges the Committee to designate the Medical Follow Up Agency (MFUA) as the repository of the data from NVVRS, NVVLS, and all other such studies. Dr. Richard De Bakey was instrumental in founding MFUA following World War II. Their database was used to finally be able to identify Hepatitis C in 1987. VVA urges that all data from all such large scale studies go to MFUA, along with funds to maintain and properly automate and search said data.

VVA further urges that you ask for a specific line item of $4 million to go to MFUA this year and to direct VA to turn over all such data to MFUA immediately.

Further, VVA strongly urges the Congress to mandate and fund longitudinal studies to begin virtually immediately, using the exact same methodology as the NVVRS, for the following cohorts: a) Gulf War of 1991; b) Operation Iraqi Freedom; and, c) Operation Enduring Freedom.

Please take action now so that these young veterans are not placed into the same predicament Vietnam veterans find ourselves today.

HOMELESS VETERANS

Homelessness is a significant problem in the veterans' community and veterans are disproportionately represented among the homeless population. While many effective programs assist homeless veterans to become productive and self-sufficient members of their communities and Congress must ensure that the Department of Veterans Affairs has adequate funding to meet the needs of the homeless veterans who served this country so proudly in past wars and veterans of our modern day war.

HOMELESS PROVIDER GRANT AND PER DIEM PROGRAM

The Department of Veterans Affairs Homeless Grant & Per Diem Program has been in existence since 1994. This program addresses the needs of homeless veterans and supports the development of transitional, community-based housing and the delivery of supportive services. Because financial resources available to HGPD are limited, the number of grants awarded and the dollars granted are restrictive and hence many geographic areas in need suffer a loss that HGPD could address. VVA recommends increasing the Homeless Grant and Per Diem (HGPD) program

to $250 million and increasing the Supportive Services for Veteran Families (SSVF) program to $375 million for FY 2016.

HUD-VASH

The HUDVASH program was established as a partnership between the Departments of Veterans Affairs and Housing and Urban Development to combine permanent housing with supportive medical services. VVA supported passage of Public Law 110–161 which included $75 million for 7,500 Section 8 vouchers for homeless and disabled programs. Under this program, VA must provide funding for supportive services to veterans receiving rental vouchers. The FY 2016 VA budget must reflect a significant increase in funding these services.

The program "housing first" simply does not work over a protracted length of time without significant and effective supportive services. Historical data that shows each housing voucher requires approximately six thousand dollars in supportive services—such as case management, personal development and health services, transportation, etc. Rigorous evaluation of this program indicates this approach significantly reduces the incidence of homelessness among veterans challenged by chronic mental and emotional conditions, substance abuse disorders and other disabilities.

The Veterans Benefits Administration (VBA) continues to need additional resources and enhanced accountability measures. VVA recommends an additional 300 over and above the roughly 700 new staff members that are requested in the President's proposed budget for all of VBA.

COMPENSATION & PENSION

VVA recommends adding at least nine hundred staff members above the level requested by the President for the Compensation & Pension Service (C&P) specifically to be trained as adjudicators. Further, VVA strongly recommends adding an additional $75 million dollars specifically earmarked for additional training for all of those who touch a veterans' claim, institution of a competency based examination that is reviewed by an outside body that shall be used in a verification process for all of the VA personnel, veteran service organization personnel, attorneys, county and state employees, and any others who might presume to at any point touch a veterans' claim.

VOCATIONAL REHABILITATION

VVA recommends that you seek to add an additional two hundred specially trained vocational rehabilitation specialists to work with returning servicemembers who are disabled to ensure their placement into jobs or training that will directly lead to meaningful employment at a living wage. It still remains clear that the system funded through the Department of Labor simply is failing these fine young men and women when they need assistance most in rebuilding their lives.

VETERANS ECONOMIC OPPORTUNITY ADMINISTRATION AT VA

VVA strongly favors moving this function to VA in a new fourth division of VA that deals solely with helping veterans become as independent as possible. For those of working age, this means helping them successfully enter the civilian workforce. While we will address this in greater detail next week, this is a crucial aspect of the budget and planning process.

VVA has always held that the ability to obtain and sustain meaningful employment at a living wage is the absolute central event of the readjustment process. Adding additional resources and much greater accountability to the VA Vocational Rehabilitation process is essential if we as a nation are to meet our obligation to these Americans who have served their country so well, and have already sacrificed so much.

HEPATITIS C

Vietnam Veterans of America (VVA) urges you to allocate funds for life-saving treatments for veterans suffering from the hepatitis C virus (HCV) consistent with the Department of Veterans Affairs request in the President's proposed budget.

The hepatitis C virus is one of the greatest health threats facing American veterans. HCV is an infectious, blood-borne disease and the leading cause of catastrophic liver damage, cirrhosis, liver cancer and liver transplants. This potentially fatal disease can take years or decades to present symptoms, and by the time individuals feel sick—long after many veterans have left the battlefield—the disease has often already taken its toll.

Veterans are at a disproportionately high risk for the hepatitis C virus due to the potential for blood exposure in combat or medical settings. While hepatitis C is a growing epidemic across the country, where more than 3.2 million Americans are infected with the virus, it is even more rampant among veterans. Prevalence of HCV among veterans who receive care through the Veterans Health Administration is twice the rate reported in the general population.

Approximately 175,000 VA enrollees have been diagnosed with HCV and at least 30,000 have cirrhosis, a number that has doubled over the last decade. In addition, because the infection is often asymptomatic, the VA estimates that as many as 42,000 enrollees may be infected with the virus but are undiagnosed.

Revolutionary new hepatitis C treatments have given veterans hope of a cure for this deadly disease. Early detection of the hepatitis C virus through screening and access to new, more effective HCV treatments significantly decreases the progression of the disease to cirrhosis, liver failure, liver cancer, and death.

The VA has placed a high priority on ensuring that all veterans living with HCV have access to the treatments they need. We urge you to allocate the funds necessary to help the VA provide care to those affected and encourage the Agency to screen veterans to diagnose the remaining 42,000 who do not know their status.

ACCOUNTABILITY AT THE VA

There is no excuse for the dissembling and lack of accountability in so much of what happens at the VA. It is certainly better than it was a year ago, but there is a long way to go in regard to cleaning up that corporate culture to make it the kind of system it should become. VA must change so that it can be trusted to get the "biggest bang for the taxpayer's buck." It can be cleaned up and done right the first time, if there is the political will to hold people accountable for doing their job properly.

Thank you again, Mr. Chairman, for allowing VVA to be heard at this forum. We look forward to working with you and this distinguished Committee to obtain an excellent budget for the VA in this fiscal year, and to ensure the next generation of veterans' well being by enacting assured funding. I will be happy to answer any questions you and your colleagues may have.

Chairman ISAKSON. Well, I want to thank all of you. And as a testimony to the VA and its leadership, they are all sitting behind you, listening to your testimony. I think that is a credit to them and a credit to you, as well.

Let me just say first of all, I am sorry you had to wait so long to testify, but I am grateful for the quality of your testimony and I appreciate that very much.

Each one of you mentioned—you know, I sat here for two-and-a-half hours. Nobody once questioned the quality of health care in the Veterans Administration, not one statement. But, the delivery of that health care is locked in the 19th century while the quality of that health care is in the 21st century. So, I think what we have got to do is make sure the delivery system to our veterans is improved, the access is improved, and it is a state-of-the-art system; that we work with the Secretary to see to it that it happens. That is number 1.

Ms. Ilem, I agree with you on the fully-developed claim. One of the big problems, as I understand it, on the appeals now is they remain open many times and people file amendments to those claims and supplements to those claims, which protracts the decisionmaking process. I have become convinced that if we will close those claims and force people to get all their claims in and all their evidence and documentation in to have a fully-developed claim ready for review, we can speed up the system and improve the quality of claims adjudication. Would you agree with that?

Ms. ILEM. I think we want to make sure that the VSOs work with VA hand-in-hand to make sure that as many as possible could be fully developed for the appeals, like we have with the claims,

which are now up to about 40 percent of us submitting fully-developed claims. So, we want to be able to help them make sure they have the appropriate evidence. But, I think we still need—we would still need to have the out. If the veteran needs to submit something else, it will revert back to a traditional appeal.

Chairman ISAKSON. Mr. Kelley, I do not know anything about anything except real estate. That is how I made a living for 33 years. You were right on target. The leasing mechanisms at the VA are deplorable. The construction disciplines are deplorable. And, a lot of it is because they simply have not modernized the process they go through.

I have worked at locations of CBOCs in Georgia through leasing. We have amended and expanded the hospital at Clairmont Road. It is very important that we modernize the system of maintenance and operation. We are costing ourselves more money by letting deferred maintenance cause obsolescence than by having an active maintenance process that goes all along. So, I am going to work with the Secretary and the appropriate people to do exactly that.

And, to all of you, thank you for your service. Thank you for volunteering your testimony here today. It does not go unnoticed nor unpublished. We will work with you to coordinate and see to it that next year when we come back and have the same type of hearing, we can report on the successes we had in accomplishing some of the things you recommended today, to have them implemented and in place next year.

With that said, Ranking Member Blumenthal, if you have any questions or comments.

Senator BLUMENTHAL. I have a couple of brief questions. First of all, thank you for being here, thank you for your service to our Nation in uniform and afterward, as well. And, thank you for your insights in your testimony.

I think most of you—I believe all of you—were present when the panel before you testified, and you may have heard Secretary McDonald's testimony about the Choice Card Program. My question to you is whether you can share with us any insights as to why the program has been so underutilized. Is it, in fact, the interpretation of the 40-mile rule? Is it the facilities definition that may ignore whether or not, in fact, care at that facility is available? Is it some other reason? Maybe you can give us the benefit of your insights on that question.

Mr. KELLEY. I think it is a little bit of all of that. We have to keep in mind that we are only a few months into this program. VA had to implement it, begin training its personnel—and it is a complicated process, as well—to train those people to first know whether or not a veteran qualifies. How do they get hold of the person to schedule the appointment? How does that schedule get forwarded? So, it is a complicated process. I think the training within VA to get those front-line schedulers fully up to speed is critical.

I think the idea of expanding the 40 miles or going from a geodesic distance to a driving distance, obviously, is going to change and the population will increase. But, I think, until we get training down and people are fully aware of how to implement the process, it is still going to be much lower than what we would want and what we expect.

Mr. DE PLANQUE. I am going to jump onto a couple of things that my colleague just said, and yes, a lot of our initial questions were confusion about eligibility. Am I eligible, is what we have been hearing. And, this is all anecdotal at this point. However, we have had a lot of people with concerns that, as we mentioned before, I am 38 miles from a facility but it does not have the service I need, so now I have to go 300 miles for that. So, we want to make sure that those veterans are going to be able to get the access to the care.

As The American Legion was involved in the process, as we were all involved in the process of crafting this legislation last year, we wanted to be able to look at these metrics over the 3 years of the pilot program, where VA is having trouble meeting the needs, and be able to take that to know where to make VA more robust in the future; that we absolutely have seen that there are veterans who need to get access to their care and it is not being delivered through the system. It is not that veterans have problems with the care within VA. It is that they are having problems accessing it.

So, to be able to use a program like the Choice Program, that we can get veterans into care, but also see through that, this tells us that this area of the country needs to have a more robust presence from VA and build that up for the future. This is a tool that we can use to supplement, whether for the pilot or other programs that we need to develop, to supplement what is going on with VA, but still with the ultimate goal of making that VA program—that VA Health Care System one that is there to serve veterans and is built in the areas that they need it.

Because there has been some comment this morning about, you know, whether it is privatization or whether VA should only be a system for service-connected disabilities, so let us just address that right from the beginning. If you look at the myriad of conditions that can be service-connected, it affects all body systems. This is not—when I hear, it is only for service-connected conditions, that is somebody who does not understand service-connected conditions and does not understand what the veteran population who is using VA looks like.

All of these conditions need to be within VA, and by serving a community of veterans who may not be service-connected for those issues, you are still building a community of physicians that can treat those service-connected veterans who have a lesser-known condition but that is still connected to their service. So, I think it needs to be a system that is robust enough to be comprehensive and to treat the entire veterans' community that is out there.

I think we absolutely need to have a lot of focus on our service-connected veterans and in making sure we do not make problems worse for them. The VA system, it is a good system. It is an unbelievably comprehensive system that delivers great medicine because it is looking at the entire veteran. It is looking at how those service-connected conditions affect the other body systems, and I think that is important, as well.

Senator BLUMENTHAL. I appreciate both of those comments, and what they highlight to me is that there is a need to better implement this program. There is also a need to understand the issues of delivery, as Senator Isakson has correctly characterized them, as

they relate to what is happening in the private sector, as well. In other words, the VA is not the only one where there are delays between the time you ask for an appointment and the time you get one. That happens to many of us who rely on private doctors.

What really is one of the overriding challenges here to modern American medical care is the shortage of primary care physicians, nurses, and professionals in this area. The VA is reflecting those shortages, much like the canary in the mine. Unfortunately, in the VA, there was falsification of records and cooking the books that led to the investigation that is ongoing in the Inspector General, which, as I have said before, I am going to say it again, I hope comes to conclusion tomorrow. That is when we need the result.

I appreciate your making the distinctions that you do, that I think are very important for the future of VA health care, and, in effect, saying, here is where the issues are. Let us target the problems. Let us not just abandon the system. Let us make Choice work where it is needed.

I could make a pretty good legal argument that under the existing statute, that 40-mile rule could be reinterpreted. I could make a pretty good lawyer's argument, but there is an argument on the other side, too. A lot of people wish there were lawyers with only one hand so they would not say, "On the one hand, and on the other hand." [Laughter.]

I think what is necessary is clarity from the Congress to give direction that the 40-mile rule should be interpreted with common sense, not just the narrow technical wording of the statute. The intent of Congress was to provide as broad an access as possible, and that is what is perhaps lacking right now.

Thank you so much for being here. Thanks for your patience in listening to all of us, and thanks for your great work for the veterans of America.

Chairman ISAKSON. Since time is of the essence, I am not going to get into my opinion of lawyers, so——

[Laughter.]

Senator BLUMENTHAL. I am very grateful for that, Mr. Chairman.

Chairman ISAKSON. I have a great one to my right and to your left in Richard Blumenthal——

Senator BLUMENTHAL. Thank you.

Chairman ISAKSON [continuing]. Who is a great Ranking Member, who I appreciate.

I am going to introduce Senator Moran and turn the gavel over to Senator Moran, as well, because I have a pending appointment that I am about 45 minutes late for. I want to thank you for being here.

The record will be held open for 7 days to amplify your comments, correct your comments, or respond to questions that were raised or anything else you would like to submit. Thank you for your attendance today and thank you for your service to the country.

Senator Moran, it is all yours.

Senator MORAN [presiding]. Mr. Chairman, what a great opportunity. I only wish this had been the case when Secretary McDonald was—oh, he is still here, which I very much appreciate.

Mr. Chairman, thank you very much for this hearing. I appreciate what I just heard the Ranking Member, Senator Blumenthal, say. I, too, have the opinion that the interpretation could be made by the Department of Veterans Affairs, but, as you know, there is legislation to make clear that the definition of a facility would not include a facility that cannot provide the services that the veteran needs, even though it may be within the 40 miles of where the veteran lives.

Let me ask that question. Is there something that I am missing here? You were all here during my conversation with Secretary McDonald. I assume that it makes sense for the Department to do everything possible to make certain that Choice works before we ultimately make a determination about how valuable it is or how many dollars and resources are necessary to fund it. Was there something I should have asked the Secretary that I did not ask in this regard? Does anybody have suggestions for something else that needs to be pursued in regard to implementation of the Choice Act?

Mr. WEIDMAN. Senator Moran, we believe that it is the devil you know versus the devil you do not know, and this is a new thing that people have not gone through this before. Those who have gone through trying to get the bill paid on fee-basis services in the past and have finally ended up paying it themselves or going bankrupt, with that in mind, they have a hard time thinking, I am going to go outside and I am going to be liable if the VA does not pay for this.

The second thing is that, because of that same thing, some outside physicians do not want to take it, just like some do not want to take Medicare anymore.

The last thing is—in the military, we used to have a saying. You have got to tell them, you have got to tell them again, you have got to tell them that you told them, and et cetera, remind them that you told them that you told them. It takes a while for things to become familiar enough that people will step outside of what they already know very well.

Senator MORAN. Thank you. Anyone else?

Mr. BLAKE. Senator Moran, one question we would like to have answered as it relates to the Choice Program as it eventually and hopefully gets implemented widespread and appropriately, is something we have heard anecdotally, also, is that veterans are choosing Choice, taking advantage of the opportunity to go out and get purchased care in the private sector, and some veterans are returning to VA because they are finding that the option is not there even in the private sector in the areas that they live in, or that the wait times are just as long. We have expressed this to some of the folks at VA who are monitoring this, too, and we would like to know where you are seeing that problem and how prevalent it is, because it speaks a little bit to—if we have a concern, it is that there seems to be this inherent assumption that, well, the private sector can help us fix this problem. I am not sure that is wholly a true answer.

Senator MORAN. Well, it allows me to soapbox on the ARCH Program, which was designed in advance, in a sense, of the Choice Act to create the pilot program to figure out how to fix some of the problems that might arise, such as medical records, communica-

tions between the VA and the outside provider. It does not seem to me that the VA has adequately utilized ARCH as a pilot program to determine how best to now, in a sense, implement the Choice Act.

There is no one here who would—that is a leading question. No one would disagree with me that if——

[Laughter.]

Senator MORAN [continuing]. If you are a veteran that lives within 40 miles of an outpatient clinic that does not provide a colonoscopy, that you ought to be able to get those services at home, if they are provided and if that is what you want, and not be denied simply because there is an outpatient clinic within that 40 miles, even though it does not provide the service that you need. Is that—does everyone agree with that?

Mr. BLAKE. Senator, I explicitly remember the question being asked in one of our many meetings we had with VA about the question of, if the service is not available, how will that be handled? Clearly, VA has taken the strict interpretation of the law as it is written. If I looked up facility—somebody suggested, you know, is a facility defined as a place that cannot provide the service, well, it probably does not have any kind of definition relating to that if you looked it up in the dictionary. So, that is a challenge. This question has been asked before we were at November 5, the implementation date. I am not sure anybody is purely satisfied at this point.

Mr. KELLEY. We also have to remember that there are other non-VA care programs that VA can use at a local level. Those need to be used. PC3 could very easily have been used. There needs to be logic to this. That is what bothers veterans, is there is a lack of logic across the board. They do it here, but they do not do it here. How about this place, and that place? We need to find that logic, and that is based in standardization.

Senator MORAN. I would take what you just said and tell the Department of Veterans Affairs there are many programs—ARCH, PC3, now Choice Act. Ultimately, there ought to be a program in which they are all organized, combined, to facilitate the providing of service in a logical, responsible way, and those programs give greater opportunity, not less, for the VA to actually meet the needs of the veteran, and I think that is what we are all interested in.

The example that is so bad that it makes no sense is, the veteran calls from Hoxie, KS, who needs his eyeglasses adjusted. Hoxie is 3½–4 hours from Wichita, 3½, 4, 5 hours from Denver. But, the VA is insisting he goes to Wichita to get his eyeglasses adjusted. He is a World War II veteran. He is not going to do it. There is an optometrist in the town of 2,000 people that could do it.

Ultimately, we convinced the VA to do it, but that ought not—I certainly welcome the calls. My staff are there to help veterans. There needs to be a system that addresses this. It is like the light bulb goes off. Well, here is the logical thing to do. We have got all these array of options, Mr. Kelley, that you outlined, one of which is the PC3. There is a way to fix this, and there ultimately was, but it ought to be the norm, not the exception.

Mr. WEIDMAN. It begins with General Counsel, and we said to the new Secretary numerous times, we need to get beyond the

"General Counsel of No." When somebody does not want to do something in the VA, they just say, "Well, the General Counsel will not let us." I said, really? Is that the cousin of General Elevator and General Confusion? Who in the General Counsel's Office? We ask, all of us, very often, can we see the written opinion, and there is not one.

So, what happens within VA, all the way down to the local level, is "no" becomes the default answer instead of the default answer, "yes," what is good for the vet. How do we find a way to take care of this vet? That is absolutely a cultural change, but it is also something that only stems from people who have line authority over people saying, we are going to do this different. Default is not "no" anymore.

Senator MORAN. Thank you.

Mr. DE PLANQUE. I was going to say, you brought up the same question yesterday and our Commander, a fellow Kansan, as you know, he referred to it as crazy. He literally put it out there. When we spoke with the Ranking Member, Mr. Blumenthal, he agreed with that. I think it is a common sense thing that seems like it is going beyond crazy. If you are sitting there on one side of a lake and 38 miles across that lake is a facility, but you have to drive 150 miles of roads to get around that, or in some of the very rural States, you know, Vermont, where you just—the roads do not go that way, and so we have got to look at a common sense way to get this interpreted and get the veterans the access to the care that they need.

I think what we have seen is that there is a willingness on Capitol Hill to continue to work with the VSOs, as we get the feedback from veterans we are trying to get, to make sure we get this ironed out and interpreted in a way that we are going to get the veterans the care. I think all of us, the VA, I think the members up here of both committees in the House and Senate, I think the VSOs that are up here, we still have the same intent that we had at the beginning, which is how do we get the veterans the care, and we are trying to do that now and I think these are things that are going to help.

Senator MORAN. Mr.—I can pronounce Ian. I cannot pronounce de Planque.

Mr. DE PLANQUE. De Planque, just like "walk the plank."

Senator MORAN. Thank you. Mr. de Planque, The American Legion has endorsed the legislative solution, and I appreciate that, although it would be nice if, on the record, you will say that.

Mr. DE PLANQUE. I will say that for you on the record. We have endorsed your legislative solution to the problem.

Senator MORAN. Thank you very much.

Mr. WEIDMAN. So, does Vietnam Veterans of America.

Senator MORAN. Thank you very much. I appreciate that.

Before I change topics, let me just say this. While we seem to focus on the 40 miles, and I recognize I do that, part of what someone said earlier is the expectation of whether or not veterans can—they have tried this before and it did not work and, therefore, they are reluctant to go try it again. That is why this is a broader issue than the 40 miles. It is, can we implement this law, the Choice Act, in a way that sends a message to veterans that we have finally got

a system in process—in place that processes their claims and their health care, and the skepticism begins to disappear. That is why this is so important to get it right early so that we do not dash the hopes of good things happening at the Department of Veterans Affairs.

The final thing I would say, and I apologize to my colleague, Mr. Blumenthal, although ever since he said that the Chairman was his favorite Chairman——

[Laughter.]

Senator MORAN [continuing]. I have lost some level of regard for your——

Senator BLUMENTHAL. No, I was referring to the Acting Chairman.

Senator MORAN. Oh, it still is. All right. Thank you. I now understand. [Laughter.]

Senator Blumenthal and I are—he is the Ranking Member and I am the Commerce Committee Chairman, but one morning in here he announced that Senator Isakson was his favorite Chairman, so I have taken offense ever since.

I just wanted to thank the Vietnam Veterans for their efforts in regard to toxic substances. It is a topic that deserves more attention. Senator Blumenthal and I are cosponsors of legislation in the last Congress that we are getting ready to reintroduce in the new Congress and we want to work with all of you to make certain that many of our veterans who have experienced dramatic health consequences due to the presence of toxic substances during their term of service are cared for, but in addition to that, the concern that we have about having the necessary medical research to be then able to take care of children and grandchildren and those that follow. I think it is a hugely important topic that Senator Blumenthal and I care a lot about, and the Vietnam Veterans have been front and center with that, and I appreciate it.

Mr. WEIDMAN. We thank you and Senator Blumenthal for your leadership, sir.

Senator MORAN. I actually thought I was going to get to adjourn the meeting, but with the arrival of Senator Boozman, I would recognize him.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. I did that on purpose. [Laughter.]

No, I just wanted to apologize for not being here during the entire meeting and really wanted to thank all of you. I have enjoyed working with you so much through the years. Time goes by. In fact, Jerry and I served over on the House Veterans Committee together and now are here, and again, I just appreciate you for your advocacy, really tireless advocacy. It is everybody working together, which you can be very proud, because of your efforts, hard work, and your memberships. You really have pushed things along and that is a great thing.

One of the things that I am concerned about seeing in Arkansas is, the Choice Act and trying to make it easier on veterans. One of the concerns is that prior to that, when you had veterans with emergent care going and accessing a hospital or whatever, the VA was not paying the bill for that, or paying it very, very late. That

should not be. Now we are able to intervene and the VA on an individual basis has been good about working with us.

A concern is that as we go forward with this other program, that you have situations where the hospital wants to get paid. They are hounding the veteran. They are hounding the VA. The VA is deciding. Next, the bill collectors are out there, I guess. Can you all comment about that?

The other problem with that, also, is if you have that reputation, and we saw this with TRICARE and some other things, I can get people out of a sense of patriotism to participate in programs. Where they get in trouble is if they are hassled with unnecessary regulation or things that they have to do as far as extra paperwork or this or that. Again, everybody likes to get paid at some point, even if they are taking a lesser fee.

Can you guys comment about that, because what we do not want to do is make it such that if we leave a bad taste in our providers, then it makes it more difficult than ever for them actually to participate in the first place.

Mr. KELLEY. The good thing about the Choice Program is that the contractors will pay the provider and then VA will reimburse them. That really streamlines the process. That is a great standardization. There are some good processes in place for that. We need to figure out how to do that across the board, across all non-VA care delivery.

Mr. DE PLANQUE. One of the things as we were jumping into working on developing the Choice Program was to be able to get that kind of feedback and metrics as we see how things work, and it is going to watch how this is working and see if it can be applied across to other programs, because, as you mentioned, there have been big problems with some of the VA contracted care programs in the past, getting money to doctors, and so we want to make sure that that was part of the thing with Choice, is that we can look at this as, perhaps, a model for how to make other programs work better.

Mr. WEIDMAN. I would like—I am sorry, Joy.

Ms. ILEM. I would just add, we are also very interested in the coordination of that care; the complete coordination of that care, whether it be the payment or making sure the records get back, you know, and making sure that the veteran then gets referred back to the VA when that episode of care is done, if need be, or that there is still that continuum of care and that connection for VA in the best interests of the veteran.

Mr. WEIDMAN. It is experience. People will—vets will believe another vet who has had a successful experience, simple as that. Until you hit that critical mass where enough people have gone, you are going to have to, at each facility, walk people through the process, so that if they have confidence in the staff member, they will trust them to do it, and then they start to spread the word. Vets will believe another vet before they will believe the government by ten country miles.

Senator BOOZMAN [presiding]. Right. No, in fact, one of the things we are seeing is the underutilization of the Choice Act, which I think is a reflection on the VA brand and the fact that

there is tremendous loyalty. I think the VA can be very proud of that.

I see the Secretary sitting back there, and we appreciate you staying. I think that sends a great message, and we do appreciate your hard work.

I do want to thank you all. Like I said, I figured out a way how to become the Chairman. [Laughter.]

With that, we are adjourned.

[Whereupon, at 12:19 p.m., the Committee was adjourned.]

A P P E N D I X

The Independent Budget

for the Department of Veterans Affairs

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Budget Recommendations for FY 2016 and FY 2017

Introduction

The co-authors of *The Independent Budget* (*IB*)—AMVETS, DAV (Disabled American Veterans), Paralyzed Veterans of America, and Veterans of Foreign Wars—recognize that Congress and the Administration continue to face immense pressure to reduce federal spending. However, we believe that the ever-growing demand for healthcare and benefits services provided by the Department of Veterans Affairs (VA) certainly validates the continued need for sufficient funding. We understand that VA has fared better than most federal agencies with regard to budget proposals and appropriations.

In the past couple of years, as many federal agencies have faced immense pressure to hold down spending, the Administration has continued to request increases to discretionary funding for VA. At the same time, Congress has continued to provide increases in actual appropriated dollars. However, the serious access problems in the healthcare system identified in 2014 and the continued pressure being placed on the claims-processing system raise serious questions about the resources being provided and how VA chooses to spend the resources it is given. In fact, Deputy Secretary Gibson affirmed our concerns last year when he testified before the House Committee on Veterans' Affairs that for too long VA has been "managing to budget, not to need." This is an unacceptable practice for an agency charged with meeting the needs of the men and women who have served and sacrificed for this country.

For the first time, *The Independent Budget* veterans service organizations (IBVSOs) are jointly releasing a stand-alone report that focuses solely on the budget of VA and our projections for the VA's funding needs across all programs. This report is not meant to suggest that these are the absolute right answers for funding these service lines. However, 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 insufficient requests.

Our recommendations include funding for all discretionary programs for FY 2016 as well as advance appropriations recommendations for medical care for FY 2017. 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 for ensuring sufficient, timely, and predictable funding for VA.

VA Accounts for FY 2016 and FY 2017 Advance Appropriations

	FY 2015 Appropriation	FY 2016* Admin	FY 2016 *IB*	FY 2017 Adv Approp	FY 2017 *IB* Adv Approp
Veterans Health Administration (VHA)					
Medical Services	45,224,716	47,603,202	51,593,505	51,673,000	54,183,411
Medical Support & Compliance	5,879,700	6,144,000	5,972,489	6,524,000	6,241,506
Medical Facilities**	4,739,000	4,915,000	5,703,763	5,074,000	5,926,353
Subtotal Medical Care Discretionary	**55,843,416**	**58,662,202**	**63,269,757**	**63,271,000**	**66,351,270**
Medical Care Collections	*3,065,000*	*3,248,000*		*3,299,954*	
Total, Medical Care Budget Authority (including Collections)	***58,908,416***	***61,910,202***	***63,269,757***	***66,570,954***	***66,351,270***
Medical & Prosthetic Research	588,922	621,813	619,000		
Total, Veterans Health Admin.	**59,497,338**	**62,532,015**	**63,888,757**		
General Operating Expenses (GOE)					
Veterans Benefits Admin.	2,534,254	2,697,734	2,796,650		
General Administration	321,591	346,659	330,436		
Board of Veterans Appeals	99,294	107,884	117,853		
Total, General Operating Expenses (GOE)	**2,955,139**	**3,044,393**	**3,244,939**		
Departmental Admin. and Misc. Programs					
Information Technology	3,903,344	4,133,363	3,974,781		
National Cemetery Admin.	256,800	266,220	260,970		
Office of Inspector General	126,411	126,766	128,412		
Total, Dept. Admin. & Misc. Programs	**4,286,555**	**4,526,349**	**4,364,163**		
Construction Programs					
Construction, Major	561,800	1,143,800	1,930,000		
Construction, Minor	495,200	406,200	575,000		
Grants for State Extended Care Facilities	90,000	80,000	200,000		
Grants for State Vets Cemeteries	46,000	45,000	48,000		
Total, Construction Programs	**1,193,000**	**1,675,000**	**2,753,000**		
Other Discretionary	162,372	166,090	165,132		
Total, Discretionary Budget Authority (Including Medical Collections)	***68,094,404***	***71,943,847***	***74,415,991***		

*Amounts for health care for FY 2016 reflect the FY 2015 Consolidated and Further Continuing Appropriations Act approved in December 2014. However, the Administration has revised its FY 2016 estimated need for the three medical care accounts. The Administration projects need for an additional $1.1 billion for Medical Services, $70 million for Medical Support and Compliance, and $105 million for Medical Facilities. The new total includes **Medical Services ($48.7 billion)**, **Medical Support and Compliance ($6.2 billion)**, **and Medical Facilities ($5 billion). This results** in a new **total Medical Care estimate of $63.3 billion.**

**The *IB* Recommendation for Medical Facilities includes $900 million over the baseline for Non-Recurring Maintenance for both FY 2016 and FY 2017.

Veterans Health Administration

Total Medical Care

FY 2016 *IB* Recommendation	**$63.3 billion**
FY 2016 Revised Administration Request	**$63.2 billion**
FY 2016 Enacted Advance Appropriations	**$58.7 billion**
Medical Care Collections	***$3.2 billion***
Total	**$62.0 billion**
FY 2017 *IB* Advance Appropriations Recommendation	**$66.4 billion**
FY 2017 Administration Advance Appropriations Request	**$63.3 billion**
Medical Care Collections	***$3.3 billion***
Total	**$66.6 billion**

The IBVSOs appreciate the fact that the Administration continues to present budget recommendations for the overall Medical Care accounts that address veterans' growing demand for healthcare services. Unfortunately, we believe the advance appropriations amount for FY 2016 provided for by Congress in the "FY 2015 Consolidated and Further Continuing Appropriations Act" approved in December 2014 is not sufficient to meet the full demand for services being placed on the system. For FY 2016, the *IB* recommends approximately $63.2 billion for total Medical Care. However, Congress recently approved only $62 billion for total Medical Care (based on an assumption that includes approximately $3.3 billion for medical care collections).

Of particular concern is the fact that VA continues to over-project and underperform with its medical care collections estimates. Overestimating medical care collections affords Congress the opportunity to appropriate fewer discretionary dollars for the healthcare system. However, when VA fails to collect what VA estimated, it is left with insufficient funding to meet the actual demand by veterans. As long as this scenario continues, VA will find itself falling farther and farther behind in its ability to care for those men and women who have served and sacrificed for this nation. In fact, we believe this to be the precise situation now occurring.

Similarly, we are concerned that the Administration has not adjusted the baseline for medical care funding to account for the additional resources targeted at expanding the capacity of the system. Congress approved approximately $5.0 billion in additional funding to expand the capacity of the VA healthcare system in P.L. 113-146, the "Veterans Access, Choice and Accountability Act (VACAA)." We believe that it will be critical moving forward for VA to adjust its baseline for total Medical Care expenditures to account for the infusion of these new resources and the resultant expansion of capacity, including new permanent employment authorized by the act.

The Independent Budget also recommends approximately $66.1 billion for total Medical Care for FY 2017. This reflects an increase of approximately $4.1 billion over the amount advance-appropriated by Congress in December 2014.

Medical Services

Appropriations for FY 2016

FY 2016 *IB* Recommendation	**$51.6 billion**
FY 2016 Revised Administration Request	**$48.7 billion**
FY 2016 Enacted Advance Appropriations	**$47.6 billion**

For FY 2016, *The Independent Budget* recommends approximately $51.6 billion for Medical Services. This recommendation is a reflection of multiple components. These components include the following recommendations:

Current Services Estimate.....$49,468,647,000
Increase in Patient Workload.....$1,489,858,000
Additional Medical Care Program Costs.....$635,000,000
Total FY 2016 Medical Services.....$51,593,505,000

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. The estimate also assumes a 1.5 percent increase for pay and benefits across the board for all VA employees.

Our estimate of growth in patient workload is based on a projected increase of approximately 148,000 new unique patients. These new unique patients include priority group 1–8 veterans and covered nonveterans as well as additional new users as a result of veterans being removed from the extended waiting lists and those whose decisions on healthcare enrollment eligibility are made. We estimate the cost of these new unique patients to be approximately $1.2 billion. The increase in patient workload also includes a projected increase of 71,500 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) enrollees, as well as Operation New Dawn (OND) veterans at a cost of approximately $282 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users from FY 2002 through the 3rd quarter of FY 2014.

The Independent Budget believes that there are additional projected medical program funding needs for VA. Specifically, we believe there is real funding needed to address the array of long-term-care issues facing VA, including the shortfall in institutional capacity; to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's prosthetics service); as well as funding necessary to improve the Comprehensive Family Caregiver program; and funding to address needed improvements in programs directed for women veterans.

The Independent Budget recommends $325 million directed toward VA long-term-care programs. In order to support the continued rebalancing of VA long-term care in FY 2016, $125 million should be provided. Additionally, $95 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the $325 million ($105 million) should be dedicated to increasing the VA's long-term-care

average daily census (ADC) to the level mandated by Public Law 106-117, the "Veterans Millennium Health Care and Benefits Act."

In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $150 million. This increase in prosthetics funding reflects an increase in expenditures from FY 2014 to FY 2015 and the expected continued growth in expenditures for FY 2016. Our additional program costs recommendation includes investing $70 million in the Comprehensive Family Caregiver program in accordance with the deficiencies identified during the hearing held by the House Veterans' Affairs Subcommittee on Health in December 2014.

The Medical Services appropriation should be supplemented with $90 million designated for women's healthcare programs, in addition to those amounts already included in the FY 2016 baseline. These funds would be used to help the Veterans Health Administration deal with the continuing growth in ensuring coverage for gynecological, prenatal, and obstetric care, other gender-specific services, and for maintenance and repair of facilities hosting women's care to improve privacy and safety of these facilities where women seek care. The new funds would also aid the VHA in making its cultural transformation to embrace women veterans and welcome them to VA healthcare services, and provide means for VA to improve specialized mental health and readjustment services for women veterans.

Advance Appropriations for FY 2017

FY 2017 *IB* Advance Appropriations Recommendation	**$54.2 billion**
FY 2017 Administration Advance Appropriations Request	**$51.7 billion**

The Independent Budget once again offers baseline projections for funding through advance appropriations for the Medical Care accounts for FY 2017. While we have previously deferred to the Administration and Congress to provide sufficient funding through the advance appropriations process, we remain concerned that this responsibility is not being taken seriously.

For FY 2017, *The Independent Budget* recommends approximately $54.2 billion for Medical Services. Our Medical Services recommendation includes the following recommendations:

Current Services Estimate	$51,937,260,000
Increase in Patient Workload	$1,576,151,000
Additional Medical Care Program Costs	$670,000,000
Total FY 2017 Medical Services	$54,183,411,000

Our growth in patient workload is based on a projected increase of approximately 150,000 new unique patients. These new unique patients include priority group 1–8 veterans and covered nonveterans. We estimate the cost of these new unique patients to be approximately $1.3 billion. This recommendation also reflects an assumption that more veterans will be accessing the system as VA expands its capacity and services and we believe that reliance rates will increase as veterans examine their healthcare options as a part of the option for choice. The increase in patient workload also includes a projected increase of 74,225 new OEF/OIF, as well as OND veterans at a cost of approximately $301 million.

Last, as previously discussed, the IBVSOs believe that there are additional medical program funding needs for VA. *The Independent Budget* recommends $325 million directed toward VA long-term-care programs. In order to support the continued rebalancing of VA long-term care in FY 2017, $125 million should be provided. Additionally, $95 million should be targeted at the VA's Veteran Directed-Home and Community Based Services (VD-HCBS) program. The remainder of the $325 million ($105 million) should be dedicated to increasing the VA's long-term-care average daily census (ADC) to the level mandated by Public Law 106-117, the "Veterans Millennium Health Care and Benefits Act." In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $165 million. Our additional program costs recommendation includes continued reinvestment of $75 million in the Comprehensive Family Caregiver program in accordance with the deficiencies identified during the hearing held by the House Veterans' Affairs Subcommittee on Health in December 2014. Finally, we believe that VA should invest a minimum of $105 million as an advance appropriation in FY 2017 to expand and improve access to women veterans' healthcare programs.

Medical Support and Compliance

FY 2016 *IB* Recommendation	**$5.972 billion**
FY 2016 Revised Administration Request	**$6.214 billion**
FY 2016 Enacted Advance Appropriations	**$6.144 billion**
FY 2017 *IB* Advance Appropriations Recommendation	**$6.242 billion**
FY 2017 Administration Advance Appropriations Request	**$6.524 billion**

For Medical Support and Compliance, *The Independent Budget* recommends approximately $6.0 billion for FY 2016. Our projected increase reflects an increase in current services based on the impact of inflation on the FY 2015 appropriated level. Additionally, for FY 2017 *The Independent Budget* recommends approximately $6.2 billion for Medical Support and Compliance. This amount also reflects an increase in current services from the FY 2016 advance appropriations level.

Medical Facilities

FY 2016 *IB* Recommendation	**$5.704 billion**
FY 2016 Revised Administration Request	**$5.020 billion**
FY 2016 Enacted Advance Appropriations	**$4.915 billion**
FY 2017 *IB* Advance Appropriations Recommendation	**$5.926 billion**
FY 2017 Administration Advance Appropriations Request	**$5.074 billion**

For Medical Facilities, *The Independent Budget* recommends approximately $5.7 billion for FY 2016, nearly $800 million more than the enacted advance appropriations in December 2014. Our Medical Facilities recommendation includes the addition of $900 million to the baseline for Non-Recurring Maintenance (NRM). The Administration's request over the past two cycles represents a wholly inadequate request for NRM funding, particularly in light of the actual expenditures

that are outlined in the budget justification. While VA has actually spent on average approximately $1.3 billion yearly for NRM, the Administration has requested only approximately $460 million for NRM. This is clearly insufficient. This decision means that VA is forced to divert funds designated for another purpose to meet this need.

The Independent Budget also recommends approximately $5.9 billion for Medical Facilities for FY 2017. Our FY 2017 recommendation also includes the addition of $900 million to the baseline for NRM. Last year the Administration's recommendation for NRM reflected a projection that would place the long-term viability of the healthcare system in serious jeopardy.

Medical and Prosthetic Research

FY 2016 *IB* Recommendation	**$619 million**
FY 2016 Administration Request	**$622 million**
FY 2015 Enacted Final Appropriation	**$589 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 healthcare 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 2016 by 2.5 percent over the FY 2015 baseline—about $15 million.

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 healthcare. Denied research funding, many of them simply resign and move their research work to affiliated universities or to corporate platforms.

Program Growth

In addition to covering uncontrollable inflation, the IBVSOs believe Congress should appropriate an additional $15 million for FY 2016, for expanding research on conditions prevalent among newer veterans, as well as continuing VA's inquiries in chronic conditions of aging veterans from previous wartime periods. These additional funds would support ongoing research on

chronic conditions of aging veterans and provide funds for new and emerging research on conditions prevalent among younger veterans of our most recent overseas wars. For example, VA research 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.

Additional funding will also help VA support emerging 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 healthcare 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 multisymptom 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 tele-health and self-directed care, that lead to accessible, high-quality, cost-effective care for all veterans.

General Operating Expenses (GOE)

Veterans Benefits Administration

FY 2016 *IB* Recommendation	**$2.797 billion**
FY 2016 Administration Request	**$2.698 billion**
FY 2015 Enacted Final Appropriation	**$2.534 billion**

The Veterans Benefits Administration account is comprised of six primary divisions. These include Compensation; Pension; Education; Vocational Rehabilitation and Employment (VR&E); Housing; and Insurance. The increases provided 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 a substantial increase in staffing. The explanation for those increases is included below.

The *IB* recommends approximately $2.797 billion for the Veterans Benefits Administration (VBA) for FY 2016. This amount reflects an increase of approximately $263 million over the recently enacted FY 2015 appropriations level. Our recommendation includes approximately $159 million additional in the Compensation account above current services and approximately $42 million additional in the VR&E account above current services to provide for new full-time equivalent employees (FTEEs).

Compensation Service Personnel	**1,700 New FTEEs**	**$158.9 million**

Over the past two years, the VBA has made significant progress in addressing the backlog of pending claims for compensation, reducing the number of pending claims and increasing the accuracy rate for claims decisions. Some of this progress can be attributed to the development and deployment of a new organizational model and new information technology (IT) systems, including the Veterans Benefits Management System (VBMS), e-Benefits, and the Stakeholder Enterprise Portal (SEP). However, much of the increased productivity is the result of putting more resources into processing claims. Recognizing that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel, Congress provided the VBA with more than 3,000 FTEEs between 2008 and 2013, primarily in Compensation Service. However, relative to the VBA's total workload, to include appeals, these increases have not been significant enough to keep pace with or reduce backlogs in the claims and appeals pipelines as evidenced by VBA's own resource allocation and personnel decisions.

Over the past couple of years, VBA's largest increases in productivity—periods where the backlog declined most markedly—occurred while the VBA enforced a policy of mandatory overtime for its workforce. During holiday periods at the end of the year, when mandatory overtime was curtailed, production fell off measurably. Furthermore, over the past couple of years many VA Regional Offices (VAROs) have diverted some of their senior employees from both quality review and appeals work to focus on claims- processing work in order to drive down the backlog. Specifically, both Decision Review Officers (DROs) and Quality Review Specialists (QRSs) have been performing development and rating duties during both regular and

overtime working hours at many VAROs. The continued reliance on this supplemental claims-processing workforce clearly indicates that the VBA remains understaffed to handle its current and future claims workload.

It will take a blend of technology and people to provide veterans and their dependents with timely accurate decisions. Until that time, the processing power of personnel should not be tempered against hopes of future technological capabilities.

Although this new claims-processing system has the potential to transform the delivery and accuracy of benefits, it will be some time in the future before its full effect can be realized. For FY 2016, the IBVSOs recommend providing VBA's compensation workforce with 850 permanent FTEEs and 850 two-year temporary FTEEs. These additions require an increase in appropriations of $158.9 million.

This request is based on then-Acting VA Secretary Sloan Gibson's July 2014 budget request submitted to Congress, which was supported by the IBVSOs at that time. Such an infusion of resources simply reinforces what the IBVSOs have believed for so many years: that a more accurate staffing and production model is required to determine the true resource needs of the VBA.

The temporary FTE request is based on the "stimulus" legislation passed several years ago that allowed the VBA to hire several thousand employees for a temporary two-year terms. At the end of those two years, many of those who had been working in the VBA on a temporary basis transitioned into permanent positions made available through attrition. The IBVSOs continue to believe this to be a good approach to staffing and may prove to be even more beneficial to the VBA with its new organizational model, as well as beneficial to the training of new employees.

The IBVSOs believe that allowing the VBA to again hire employees for a two-year temporary term could supplement and/or alleviate the reliance on mandatory overtime and further reduce the backlog of disability claims to help reach VA's goal in reducing the backlog and significantly improving claims processing. Such an initiative would also provide an outstanding opportunity for the VBA to have a generous pool of fully trained, qualified candidates to choose from as replacements for full-time VBA employees who will undoubtedly be lost over the next few years because of attrition.

VR&E Service Personnel **382 New FTEEs** **$41.8 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 through five tracks: re-employment, 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 program facilitated at 94 college campuses. Additional VR&E services are provided at 71 select military installations for active duty service members undergoing

medical separations through the Department of Defense and VA's joint Integrated Disability Evaluation System.

These additional functions of VR&E personnel are undoubtedly beneficial; however, staffing levels throughout VR&E services must be commensurate with current and future demands. At the end of FY 2013, VR&E had a total of 1,343 FTEEs. The VBA projected an increase in FY 2014 and was authorized 1,442 FTEEs. In the FY 2015 budget request, the VBA did not recommend increasing this staff and was again authorized 1,442 for FY 2015, despite an increasing workload.

In order for VR&E to keep pace with demand, the IBVSOs project the total number of VR&E participants at roughly 165,000 for FY 2016, nearly 10 percent in participant growth. At present there are roughly 974 VR&E counselors managing an active client caseload of roughly 140,000 participants, which averages out to a counselor-to-client ratio of roughly 1:135.

Ideally, a reasonable client-to-counselor ratio would consist of one VR&E counselor for every 125 veterans as has been advocated by the IBVSOs for the past several years. However, the average can be somewhat misleading as there are higher and lower averages throughout VAROs. As an example, the Cleveland VAROs counselor to client ratio was 206 cases for every one VR&E counselor, and in the Fargo VARO, 64 cases for every one VR&E counselor.

In order to achieve the 1:125 counselor to client ratio in FY 2016, VR&E would require an additional 382 FTEEs, of which 277 would be dedicated as VR&E counselors and the remaining 105 employees dedicated toward support services bringing VR&E's total FTEE strength to 1,824.

While increased staffing levels are required to provide efficient and timely services to veterans utilizing VR&E services, it is also essential that these increases be properly distributed throughout all of VR&E to ensure that VR&E counselors' caseloads are equitably balanced among VAROs.

General Administration

FY 2016 *IB* Recommendation	**$330 million**
FY 2016 Administration Request	**$347 million**
FY 2015 Enacted Final Appropriation	**$322 million**

The General Administration account is comprised of nine 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 Policy and Planning; the Office of Operations, Security and Preparedness; the Office Public and Intergovernmental Affairs; the Office of Congressional and Legislative Affairs; and the Office of Acquisition, Logistics, and Construction. For FY 2016, the *IB* recommends approximately $330 million, an increase of nearly $8.0 million over the FY 2015 appropriation level. This increase reflects only an increase in current services based on the impact of uncontrollable inflation across all of the General Administration accounts.

Board of Veterans' Appeals

FY 2016 *IB* Recommendation	**$118 million**
FY 2016 Administration Request	**$108 million**
FY 2015 Enacted Final Appropriation	**$99 million**

The Independent Budget recommendation for the Board of Veterans' Appeals (Board) reflects two considerations. The baseline of the Board recommendation represents an increase in current services based on inflation. Our recommendation then includes funding for additional FTEEs for the Board. For FY 2016, the IBVSOs recommend $118 million to fully fund the operations of the Board and increase its staffing level by 120 FTEEs.

Board of Veterans' Appeals Personnel **120 New FTEEs** **$17 million**

After several years of declining workforce, the Board has significantly increased its FTEE levels over the past two years, rising from an average of 510 FTEEs in FY 2012 to an authorized 640 FTEs in FY 2015. Since approximately 18 months of training and orientation are required for a new Board attorney to reach full productivity, and given the time taken away from existing staff to train and mentor new staff, there will still be some expected increases in productivity to be made this year even without future increases in staffing. Over the past five years, the Board has averaged approximately 90 appeals dispositions per FTEE, producing a record 55,532 decisions in FY 2014. However, with the inventory of pending appeals now topping 360,000 in various stages at both the VBA and the Board, there are simply not enough hands to do all the work that will be required, even with further efficiencies gained through technology and other reforms. Furthermore, as the number of claims processed annually continues to rise with increased productivity by the VBA, the number of appeals is also expected to rise, even accounting for increased accuracy in rating board decisions.

In order to meet current and future workload requirements, the Board will need to continue adding new attorneys and veteran law judges, as well as sufficient support staff. For FY 2016, the IBVSOs recommend an increase of 120 new FTEEs, a 20 percent increase over the FY 2015 authorized level. This increase represents a balance between the total requirement for staffing at the Board, which is likely even higher, and the ability of the Board to absorb new personnel without undue disruption in a single year.

Departmental Administration and Miscellaneous Programs

Information Technology

FY 2016 *IB* Recommendation	**$3.975 billion**
FY 2016 Administration Request	**$4.133 billion**
FY 2015 Enacted Final Appropriation	**$3.903 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 has been publicly praised by the President and many independent observers. However, VistA is aging and is in urgent need of replacement. One of its component parts, the outdated scheduling module, contributed to VA's recent access to care scandal, and is being replaced on an expedited basis.

Meanwhile, the VBA has completed implementation of a new organizational model and system in order to fix the broken veterans benefits claims-processing system. For more than five years, the VBA has been engaged in a comprehensive transformation process designed to transition from paper-based processing. The initiative is working and merits continued support for the current transformation efforts

For FY 2016, the IBVSOs recommend approximately $4.0 billion for the administration of the VA's IT program. This recommendation does not include any new funding above the planned current services level. Significant resources have already been invested into 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. However, we do believe a portion of the IT appropriation should be directed specifically at acceleration of the VBMS and at modernization of the BVA IT system. A detailed explanation of those recommendations is included below.

VBMS Acceleration **$60 million**

The most critical and dramatic elements of the VBA's claims-processing transformation have been the new IT systems—the VBMS, e-Benefits, and SEP—built over the past five years. These three systems have led the way in moving claims processing from an outdated, paper-based system to a modern, automated digital system. Despite some early challenges, the VBMS program has proven to be an effective platform for processing claims in a digital environment, but more must be done.

Because of budget constraints, current planning at the VBA calls for some critical elements of the claims process, including major new modules to allow electronic transmission of examinations and service treatment records from the Department of Defense, other government agencies, and private businesses and organizations, to be slowly phased in over the next several years. The VBMS has also yet to fully address veterans service organization stakeholder

requirements to enhance the ability of certified service officers to fully represent veterans in the claims process.

The IBVSOs recommend increasing the amount of IT funding allocated to the VBMS program in FY 2016 by $60 million to support the specific IT enhancements referenced above, which are already planned, but have been pushed forward to future years solely due to budget constraints.

Board of Veterans' Appeals IT Modernization **$15 million**

Similarly, the extension and adaptation of the VBMS for the Board's use has also been pushed back to future years due to limited budgets made available to the VBMS program. While the Board has access to e-Folders to review claims records, they do not have the ability to process appeals within a fully electronic environment. With the inventory of pending appeals at both VBA and the Board growing, it is imperative that IT modernization at the Board move forward. The IBVSOs recommend that $15 million be allocated in FY 2016 to move forward as expeditiously as feasible with the Board's IT modernization.

National Cemetery Administration

FY 2016 *IB* Recommendation	**$261 million**
FY 2016 Administration Request	**$266 million**
FY 2015 Enacted Final Appropriation	**$257 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, including:

- interring veterans and their eligible family members in national cemeteries;
- maintaining the graves and cemetery grounds as national shrines;
- providing aid to individual states and tribal organizations in establishing, maintaining, and expanding existing veteran cemeteries;
- furnishing headstones and markers for eligible individuals in national, state, or tribal veterans cemeteries and private cemeteries;
- furnishing commemorative medallions to be affixed to privately purchased headstones;
- issuing Presidential Memorial Certificates to the families of deceased veterans in recognition of their loved ones service to the nation;
- providing outer burial receptacles or partial reimbursement for privately purchased receptacles for each new gravesite in NCA-administered cemeteries;
- initiating and confirming all information necessary for the interment process in the NCA system, to including recording First Notice of (Veterans) Death; requests for flags, headstones, or markers; burial applications; and entering insurance information into VA IT systems.

In a strategic effort to meet the burial and access needs of our veterans and eligible family members, the NCA continues to expand and improve the national cemetery system, by adding

new and/or expanded national cemeteries. Not surprising, due to the opening of additional national cemeteries, the NCA is expecting an increase in the number of annual veteran interments through 2017 to roughly 130,000, up from 125,180 in 2014; this number is expected to slowly decrease to 126,000 by 2020. This much need 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 3.9 million by 2020.

Even as the NCA continues to add veteran burial space to within its expanding system, many existing cemeteries are exhausting their capacity and will no longer be able to inter casketed or cremated remains. In fact, as of 2016, the NCA expects four national cemeteries—Baltimore, Maryland; Nashville, Tennessee; Danville, Virginia; and Alexandria, Virginia—to reach their maximum capacity and will be closed to first interments, though they will continue to accept second interments.

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.

Additional areas of growth within the NCA system include:

- an increase in the issuance of Presidential Memorial Certificates, which is expected to increase from approximately 654,000 in 2013 to more than 870,000 in 2017;
- the expected increase in the burial of indigenous veterans; and
- the possible increase, thanks to local historians and other interested stakeholders, in requests for headstones or markers for previously unidentified veterans.

Budgetary Resources for NCA Programs

With the above considerations in mind, *The Independent Budget* recommends $261 million for FY 2016 for the Operations & Maintenance of the NCA. The IBVSOs believe that this should include a minimum of $20 million for the National Shrine Initiative. Since FY 2013, national shrine funding has decreased from $33.9 million to $9.1 million projected in FY 2015. The NCA must continue to invest sufficient resources in the National Shrine Initiative to ensure that this important work is completed.

Office of the Inspector General

FY 2016 *IB* Recommendation	**$128 million**
FY 2016 Administration Request	**$127 million**
FY 2015 Enacted Final Appropriation	**$126 million**

The Office of the Inspector General (OIG) has been under significant scrutiny over the past year. We believe that the work requirements assigned to this office 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. The nature of the reporting and the scrutiny that the OIG has faced suggests that internal reform should be considered before significant new resources are appropriated. The *IB* recommends funding based on current services of approximately $128 million.

Construction Programs

Major Construction

FY 2016 *IB* Recommendation	**$1.93 billion**
FY 2016 Administration Request	**$1.14 billion**
FY 2015 Enacted Final Appropriation	**$562 million**

Each year the Department of Veterans Affairs outlines its current and future major construction needs in its annual Strategic Capital Investment Planning (SCIP) process. In its FY 2015 report, VA projects it will take between $18.1 billion to $22.1 billion to close all current and projected gaps in access, utilization, and safety. Currently, VA has more than 50 major construction projects that are either partially funded or funded through completion, but in which construction is incomplete.

Last year VA requested and Congress appropriated approximately $562 million to further fund four major construction projects. While these funds will allow VA to begin substantive construction on these projects, many other previously funded sites continue to go unfunded. One of these projects was originally funded in FY 2007, while others were funded more than five years ago but no money has been spent on the projects to date. Of the 49 projects on VA's partially funded VHA construction list, 12 are seismic in nature, with nine of them being in some stage of funding.

It is time for the projects that have been in limbo for years or that present a safety risk to veterans and employees to be put on a course to completion within the next five years. To accomplish this, the IBVSOs recommend that Congress appropriate $1.93 billion for FY 2016 to fund through completion the 10 highest priority projects. On an urgent basis, Congress must fund the full cost to replace any funds that have been reprogrammed from existing projects to allow construction on the Denver VA Medical Center replacement facility to be concluded.

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 impact of funding shortages was vividly demonstrated in a Congressionally mandated report that found major, systemwide deficits in VA research infrastructure. Nearly 40 percent of the deficiencies found were designated "Priority 1: Immediate needs, including corrective action to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and/or correct life safety hazards."

The report cited above estimated that approximately $774 million would be needed to correct all deficiencies found, but only a fraction of that funding has been appropriated since this report was made public in 2012. The VA Office of Research and Development is conducting a follow-up study of over a dozen key research sites. This update should be available in mid-2015, the results

of which can be used to guide VA and Congress in further investment in VA research infrastructure. Nevertheless, Congress needs to begin now to correct the most urgent of these known infrastructure deficiencies, especially those that concern life-safety hazards for VA scientists and staff, and for veterans who volunteer as research subjects.

The IBVSOs believe that Congress should break this chronic stalemate and designate funds to improve specific VA research facilities in FY 2016 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.

The full report discussed above is available at www.aamc.org/varpt. The House reports associated with this issue are House Report 109-95, and House Report 111-559.

Minor Construction

FY 2016 *IB* Recommendation	**$575 million**
FY 2016 Administration Request	**$406 million**
FY 2015 Enacted Final Appropriation	**$495 million**

In FY 2015, VA requested and Congress appropriated $495 million for 47 minor construction projects. That still leaves more than 600 minor construction projects that need funded to close all current and future year gaps within ten years. To complete all of these current and projected projects, VA will need to invest between $6.7 and $8.2 billion over the next decade.

In August 2014, the President signed the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 133-146. In this law Congress provided $5 billion to increase healthcare access by increasing medical staffing levels and investing in infrastructure. VA has developed a spending plan that will obligate $511 million for 64 minor construction projects over a two-year period.

VA plans to invest $383 million of these funds in FY 2015, leaving $128 million for minor projects in FY 2016. It is important to remember that these funds are a supplement to, not a replacement of, annual appropriations for minor construction projects. To ensure that VA funding keeps pace with completing all current and future minor construction projects, the IBVSOs recommend that Congress appropriate an additional $575 million above the $128 million that is provided through VACAA for FY 2016.

Additionally, the IBVSOs recommend $175 million in non-recurring maintenance and minor construction funding to address needs of facilities identified in the Congressionally requested report on the status of VA research facilities.

Grants for State Extended-Care Facilities

(State Home Construction Grants)

FY 2016 *IB* Recommendation	**$200 million**
FY 2016 Administration Request	**$80 million**
FY 2015 Enacted Final Appropriation	**$90 million**

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. Today, State Homes provide over 30,000 nursing home and domiciliary beds for veterans, their spouses, and gold-star parents of veterans. Overall, State Homes provide approximately 53 percent of VA's long-term-care workload, for the very reasonable cost of only about 12 percent of VA's long-term-care budget. VA's basic per diem payment for skilled nursing care in State Homes is approximately $100, significantly less than comparable costs for operating VA's own long-term-care facilities. On average, the daily cost of care for a veteran at a State Home is less than 50 percent of the cost of care at a VA long-term-care facility. This basic per diem covers about 30 percent of the cost of care, with states responsible for the balance, utilizing both state funding and other sources.

VA also provides states with construction grants to 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 qualify are included in VA's Priority List Group 1 projects, which are eligible for funding. Those who have not yet received assurances of state matching funding are put on the list among Priority Groups 2 through 7.

In FY 2014, the estimated federal share for proposed State Home Construction Grants submitted by states was $928 million, of which $489 million had already secured the state matching funds required to put them in the Priority Group List 1. The IBVSOs had recommended $250 million to provide funding for about half of the Priority 1 projects. The final appropriated funding for FY 2014 was only $85 million, significantly less than the amount needed to address the current backlog of projects.

In FY 2015, total estimated share of State Home Construction Grant requests rose to $976 million, of which $409 million already have state matching funding. For FY 2015, Congress appropriated $90 million for this program, which does represent a small increase, but again does not begin to seriously address the backlog of pending construction requests to maintain the State Homes infrastructure.

For FY 2016, the IBVSOs recommend $200 million for the State Home Construction Grant program, which we estimate would provide sufficient funding for approximately half of the projects expected to be on the FY 2016 VA Priority Group 1 List when it is released at the end of this year.

Grants for State Veterans Cemeteries

FY 2016 *IB* Recommendation	**$48 million**
FY 2016 Administration Request	**$45 million**
FY 2015 Enacted Final Appropriation	**$46 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 veterans' cemeteries. The NCA provides the remaining funding for construction and operational funds, as well as cemetery design assistance. As of September 2014, there were 49 projects with state matching funds.

Funding eight projects in FY 2016 will provide burial options for an additional 148,000 veterans. To fund these projects, Congress must appropriate $48 million.