MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR 2018

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES

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NOTE: Under committee rules, Mr. Frelinghuysen, as chairman of the full committee, and Mrs. Lowey, as ranking minority member of the full committee, are authorized to sit as members of all subcommittees.

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MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR 2018

WEDNESDAY, MAY 3, 2017.

DEPARTMENT OF VETERANS AFFAIRS

WITNESS

HON. DAVID J. SHULKIN, SECRETARY OF VETERANS AFFAIRS

CHAIRMAN DENT OPENING STATEMENT

Mr. DENT. Good morning.

Today, we are pleased to welcome back a good friend, Dr. David Shulkin, the new secretary of the Department of Veterans Affairs. The last time you appeared before the committee, you were VA. Under Secretary for Health. Now, you have been kicked upstairs after a unanimous Senate confirmation vote—to repeat that, it was unanimous and that says a lot in this political environment. So congratulations.

With your extensive health background, I know you have got a great background in the Philadelphia area. I just learned, too, you were in Morristown in Chairman Frelinghuysen's district for some time. You certainly bring a lot of experience to the job, although I am sure these days that the challenges are very daunting for you.

We realize this hearing is a little bit unusual. Rather than the typical budget hearing we usually have at this time of year, we are limited to a discussion of the skinny budget materials that OMB had sent to the Hill in March. The two-page entry for the VA doesn't give us much to go on in terms of program priorities or plans for the Choice successor program.

But the skinny budget does give us one remarkable bit of news for the VA. Apparently, the administration is proposing a $4.4 billion or 6 percent funding increase for the agency. In addition, there is $2.9 billion proposed in new mandatory funding for the VA. You are probably the only domestic federal agency not facing a substantial cut. And so I suspect I am going to need a Kevlar vest when talking to my fellow Appropriations subcommittee chairmen.

So when we see your full budget later this month, we will be asking some tough questions about the merits of your proposed increases when we know others will be struggling.

Despite not having a complete budget, I am sure the members will find plenty of VA topics to ask you about this morning: How do you envision VA striking a balance between care in VA facilities, versus non-VA community facilities; making the electronic health

record work for veterans, especially as they see more doctors through Choice; your efforts to tackle appointment scheduling problems; how you plan to approach disability claim backlogs and appeals; your plans to decrease veteran suicide and homelessness; your campaign to limit opioid abuse among veterans; and plans to access care for rural and female veterans.

And that is probably just a start. The members will think of other things I am sure.

So Mr. Secretary, we are going to include your full statement today in the hearing record, and we will be pleased to hear your oral statement. But before you begin, I will ask our ranking member, Ms. Wasserman Schultz, if she has any opening comments that she would like to make, then after that, the chair and the ranking member of the full committee.

With that, Ms. Wasserman Schultz is recognized.

RANKING MEMBER WASSERMAN SCHULTZ OPENING STATEMENT

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

And welcome, Mr. Secretary. It has been a pleasure to talk with you over the last few weeks and good to have you in my office yesterday.

We do appreciate you being here in your new capacity and I echo the chairman's comments, particularly given that it is an awkward situation that we find ourselves in. You are operating on a bigger stage than you were previously, and with greater responsibility that comes with the duties of being the secretary of VA.

Mr. Chairman, since fiscal year 2008, the VA has seen a tremendous 70 percent increase in DVA accounts. DVA medical accounts have grown from $36.7 billion to $64.4 billion. And the overall discretionary accounts have increased from $43.6 billion to $74.3 billion. And fiscal year 2018 is no different. The President's skinny budget even requests $78.9 billion for a 6 percent increase from the 2017 enacted level.

The 2018 budget also requests legislative authority and $3.5 billion in mandatory authority to continue the Veterans Choice Program. And what is a question that arises is that this would support a program that was initially meant as a stop-gap temporary fund.

Mr. Secretary, while I am certainly, you know, thrilled to have you here today, it is unfortunate that we won't be able to discuss the specifics of the VA budget request. And the lack of detail makes it extremely challenging for the committee to properly do our job.

Moreover, given this 70 percent increase over the past 10 years, it is critical that this committee has the opportunity to analyze and understand these numbers, as well as know more about why the VA continues to have issues of mismanagement, wait times and less than adequate care.

While I can understand that this degree of growth has its growing pains, it is crucial that we understand how these issues are being addressed. And once we more fully understand those issues, at what point do we ask if this continued growth is unsustainable?

Mr. Secretary, I ask these questions with genuine concern for the future of the VA.

Obviously our driving concern must be to provide the best care to our veterans. However, if we don't control costs and ensure that

the resources this committee provides are used in an appropriate and efficient fashion, we actually hurt our ability to help veterans and deliver on our mission of providing top-quality care.

You know, it comes to mind to that, while we are providing additional resources, we are not seeing what would normally come as the commensurate response from the people who are receiving these services, because of the challenges that the VA is having in providing those services efficiently.

Top-quality care is really our top priority and we need to make sure that we help you deliver on that mission.

With that in mind, Mr. Chairman, it is imperative that we discuss a number of key issues, including the Choice program and the state of the VA's electronic health records.

How does the VA envision Choice, a mandatory program, working with Community Care, a discretionary program? After creating the Community Care Account, which includes $9.4 billion in advance fiscal year 2018 appropriations, why does the budget request also include $3.5 billion for the Choice program?

Additionally, where is the VA in implementing and improving its electronic health records system, and in executing Congress' mandate for full interoperability with the DOD systems? As we discussed this past Monday in my office, Mr. Secretary, a solution to this issue is long overdue.

And finally, I hope you can address the significant number of vacancies at the department and when these positions are expected to be filled. Currently, 11 Senate-confirmable positions remain vacant, including the under secretary for benefits, the under secretary for health, the under secretary for memorial affairs, the general counsel, the assistant secretary for information and technology, the assistant secretary for policy and planning, the assistant secretary for management and the chairman of the Board of Veterans Appeals.

And by the way, the veterans' appeals process is an absolute mess. And so for it to have no chair for as long as that has occurred is really unacceptable.

And from our discussions, I really believe that you earnestly want to reform and improve the VA It is reflective in the confidence that was placed in you, with a unanimous vote for your confirmation from the United States Senate.

And it is our duty, I believe, to ensure that you have adequate resources to do so and the proper oversight is in place to guard against abuses and mismanagement. As you can see, we have a lot to discuss today.

And, Mr. Chairman, thank you for the opportunity to share my concerns, and I yield back.

Mr. DENT. Thank you, ranking member.

At this time, I would like to recognize the chair of the full committee, Mr. Frelinghuysen of New Jersey.

FULL COMMITTEE CHAIRMAN OPENING STATEMENT

The CHAIRMAN. Great. Thank you, Chairman Dent and Ranking Member Wasserman Schultz.

So, first of all, I want to give you a shout-out for passing your bill last year, September. Thank you for that effort. You were the

pace setters. I wish we could have followed your pace, but in reality, we didn't. But I can't think of a more important department than the Department of Veterans Affairs.

I mean, those who have served our country, and serve our country right now in dangerous places, deserve, when they get home, to get the best care possible. And I know you from your time in New Jersey and the wonderful things you did there.

And, for good reasons, you were unanimously confirmed by the Senate. There is not a lot of unanimity over there, but I am glad that they focused their attention and support for you.

Two areas of particular interest to me—I don't want to take time away from your remarks or your questions. The continuing appeals and benefits backlog, it is a nightmare. I have even shared with you some of the 3- or 4-year waiting periods for people. Obviously, evidence has to be collected and verified, but in reality, it is a pretty nightmarish prospect, and certainly the confirmation of your undersecretaries might be helpful in that regard. So hopefully that will happen.

And over the years this has been a continual interest to me—is electronic medical records. I think, 3 years ago, then-Chairman Rogers hosted Chuck Hagel, the Secretary of Defense, and Ric Shinseki, one of your predecessors. And we received a commitment from former General Shinseki that we would have, within a year, some sort of a solution.

I know the Department of Defense—and, given the resources they have been given—is getting up to speed. But I do view your systems as sort of the weak link.

So I just personally feel that this is something which is enormously important. In a day and age when we have so much information passing back and forth, obviously, encrypted and protected, to not have that available to our health care providers is pretty inexcusable.

But good luck and Godspeed, and thank you, Mr. Chairman.

FULL COMMITTEE RANKING MEMBER OPENING STATEMENT

Mr. DENT. Mrs. Lowey, I would like to recognize you.

Mrs. LOWEY. Thank you very much. And I would like to thank Chairman Dent and Ranking Member Wasserman Schultz for holding this important hearing.

And I welcome Secretary Shulkin today.

We as members of Congress, and you as the Secretary of Veterans Affairs, have a duty to provide the best care available to our veterans, who have sacrificed and faithfully served our Nation. The VA faces serious challenges in meeting their health needs.

After working 4 years to reduce the claims backlog, it is once again increasing, and the Choice Program will soon run out of money and is in need of reform.

And the VA and Department of Defense are not significantly closer to the interoperability of electronic health records than they were years ago. We owe it to all current and future veterans to tackle these challenges now, and this subcommittee is committed to achieving that goal.

I must say, after reading your resume, I am so optimistic. As was referenced before, Chairman Rogers and I had, I think, four hear-

ings, right, Chairman Frelinghuysen? We also met in closed-door sessions. We hadn't been able to resolve this.

Now, I have my own personal preference about who is to blame, as we were talking about it before, but that is irrelevant now. And, looking at your resume, I am so enthusiastic, and I know you are going to get this done.

In my own district, I have worked to secure federal funding to improve rehab facilities and ensure that veterans can receive a high quality of care. But for too many, the VA is unable to provide the types of services they require.

From women struggling to find care in a health system that has traditionally served men to veterans who were turned away from VA facilities when they are most in need, the VA has a responsibility to serve all veterans who seek the care and treatment they have earned.

In light of these challenges, Congress awaits the details of the President's fiscal year 2018 budget request. The budget framework requests an increase of 6 percent for the VA, but lacks detail, providing just seven bullet points of vague proposals. While you may not be able to speak to details of the budget proposal now, I hope you will return after its release so we can fully discuss it.

Mr. Secretary, I again thank you for being here today. Thank you for your commitment to improving the lives of veterans, and thank you for assuming the responsibility. I look forward to hearing about all your success, sooner rather than later, so we won't, in a bipartisan way, continue to talk about backlogs and the lack of records.

So we have confidence in you and I thank you for appearing here today.

Mr. DENT. Thank you, Mrs. Lowey. At this time I would like to recognize Secretary Shulkin for 5 minutes.

SECRETARY SHULKIN OPENING STATEMENT

Secretary SHULKIN. Chairman Frelinghuysen, Chairman Dent, Ranking Member Lowey, Ranking Member Wasserman Schultz, and all of you who are here today, I was so impressed with your opening statements and so many topics that you have thought about and that you care about, and that I know are serious issues—and we are trying to do things differently at the VA—that I have a terrific opening statement.

But I am willing to—Mr. Chairman, to actually forgo it and get right into your questions, unless you would prefer me to go through the opening statement, because I think we have so many issues, and I want to use your time—most valuable. I have submitted it for the record. I would be glad to read through it, read through my whole statement, but I will leave it up to you.

You would like to hear it?

Mr. DENT. Yes.

Secretary SHULKIN. Good. Okay. Okay. I told you, it is terrific.

Mr. DENT. The abridged version, about 5 minutes' worth.

Secretary SHULKIN. Okay. I will try to do it quickly, but thank you.

Okay. So thanks for the opportunity to be here today to talk about the President's 2018 budget. I also want to thank you all for

your support of the 2017 budget that really gave us, for the first time, our full budget from the start of the fiscal year.

It really speaks well of the U.S. Congress, and really, of the American people, that, despite all these differences—and you have mentioned this several times—that we can come together on this topic to support our Nation's veterans. I have submitted the full statement for the record.

The President's 2018 budget reflects his strong personal commitment to our Nation's veterans. It provides the necessary resources to continue the ongoing modernization of the VA system.

The budget requests $78.9 billion in discretionary funding for VA, a 6 percent increase from the 2017-enacted level. It provides $4.6 billion more for medical care, a 7.1 percent increase, and the $3.5 billion more in mandatory budget authority that was mentioned to continue the Veterans Choice Program.

More veterans are opting for Choice than ever before—five times more in fiscal year 2016 than fiscal year 2015—and Choice authorizations are still rising. We have issued 35 percent more authorizations in the first quarter of fiscal year 2017 than in the same quarter of 2016. All told, including both care VA facilities and in the community, we project a 6.6 percent increase in ambulatory care for 2018 over 2016.

I urge you to support and fully fund our 2018 request to enable VA to meet increasing demand for VA services, to modernize the VA systems and to invest in choice.

As you know, I came to VA during a time of crisis, when it was clear that veterans were not getting the timely access to high-quality health care they deserved. I know VA has made significant progress in improving care and services to veterans, but I also know that much more must be done if VA is to continue keeping President Lincoln's promise to care for those who have borne the battle.

Last week, I had an opportunity to meet two courageous young Americans, Michael and Sarah Verardo of Rhode Island. All Michael ever wanted to do was to be a soldier, and he became a soldier serving his country—serving in the Army's 82nd Airborne Division.

Then he lost a leg and part of his arm in an IED explosion in Afghanistan. He suffered other wounds as well. They told me, when he sought care from the VA in 2014, they did not receive the care. We cannot allow ourselves to ever again fail our American heroes like the Verardos. Meeting Michael and Sarah underscored for me the urgency of VA modernization.

My five priorities as Secretary are to provide greater choice for veterans, to modernize their systems, to focus resources more efficiently, to improve the timeliness of our services and suicide prevention among veterans.

We are already taking bold steps towards each of these priorities. Two weeks ago, the President signed a reauthorization of the Veterans Choice Act, ensuring veterans can continue to get care from community providers.

Just last week, the President ordered the establishment of a VA. Accountability Office, and we are moving as quickly as we can within the limits of the law to remove bad employees.

VA has removed medical center directors in San Juan, Shreveport, Louisiana, and recently, we have relieved the medical center director right here in Washington, D.C., and removed three other executive service leaders due to misconduct or poor performance.

We simply cannot tolerate employees who act counter to our values or put veterans at risk.

Since January of this year, we have authorized an estimated 6.1 million community care appointments, 1.8 million more than last year, a 42 percent increase. We now have same-day services for primary care and mental health at all of our medical centers across the country.

Veterans can now access wait-time data for their local VA facilities by using the easy online tool where they can see those wait times. No other health care system in the country has this type of transparency.

VA is setting new trends with public-private partnerships. Last month, we announced a public-private partnership of an ambulatory care development center with a donation of roughly $30 million in Omaha, Nebraska, thanks to Mr. Fortenberry's help there. Veterans now have—or will have a facility that is being built with far fewer taxpayer dollars than in the past.

Finally, VA is saving lives. My top clinical priority is suicide prevention. On average, 20 veterans a day die by suicide. A few months ago, the Veterans Crisis Line had a rollover rate to a backup center of more than 30 percent. Today, that rate is less than 1 percent.

In support of our efforts to reduce suicides, we have launched new predictive modeling tools that allow VA to provide proactive care and support for veterans who are at the highest risk of suicide. And I have recently announced that VA will be providing emergency mental health care to former service members with other than honorable discharges at all of our medical facilities. We know that these veterans are at greater risk for suicide, and we are now caring for them as well as we can.

These are just a few of the efforts that are under way, but are already improving the lives of veterans. But to keep moving forward, we need your help. We need Congress to help us realign our capital infrastructure, to dispose of property we don't need and to support facilities where veterans can get better served.

We need Congress to fund our I.T. modernization to keep our legacy systems from failing and to increase the interoperability of electronic health records essential to any high-performing integrated health system. We are also weighing options for adopting a commercial off-the-shelf alternative to our legacy systems. I have scheduled the decision for this in July.

If it makes sense to go to the off-the-shelf route, we will need some additional support from you as well.

We need Congress to authorize the overhaul of our broken and failing claims appeals process that many of you have mentioned. Working closely with veteran service organizations and other stakeholders, VA has drafted legislation to modernize the system.

We have submitted our proposal to the 114th Congress, and we have resubmitted it in this current Congress. We need Congress to act on this.

Most of all, we need Congress to ensure the continued success of choice for veterans. Extending the Choice Program past its August end date was an absolute necessity, and thank you for that. But extending the program was just the next step towards the modernization of community care that veterans deserve.

We have charted a course for modernization and are already moving forward, but we need your help to keep up with the Choice Program's growth, maintain our momentum, and make our community care plan a reality for all veterans for generations to come.

In closing, let me again express my thanks to the Appropriations Committee and to this subcommittee for the support that you have shown veterans in recent years. Without that support, we could not have expanded Choice to a record number of veterans while also curing so many veterans of hepatitis C. You have made that possible, and 77,000 veterans are now free of hepatitis C as a result.

Thank you for the opportunity to be here today. I look forward to all the questions that you may have.

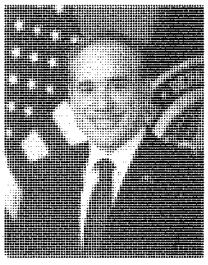
[The information follows:]

Department of Veterans Affairs

Senior Executive Biography

David J. Shulkin, M.D.

Secretary of Veterans Affairs



The Honorable David J. Shulkin was nominated by President Trump to serve as the ninth Secretary of Veterans Affairs (VA) and was confirmed by the United States Senate on February 13, 2017.

Prior to his confirmation as Secretary, Dr. Shulkin served as VA's Under Secretary for Health for 18 months, leading the Nation's largest integrated health care system, with over 1,700 sites of care serving nearly nine million Veterans.

Before he began his service with VA, Dr. Shulkin held numerous chief executive roles at Morristown Medical Center, and the Atlantic Health System Accountable Care Organization. He also served as President and CEO of Beth Israel Medical Center in New York City.

Dr. Shulkin has held numerous physician leadership roles including Chief Medical Officer of the University of Pennsylvania Health System, Temple University Hospital, and the Medical College of Pennsylvania Hospital. He has also held academic positions including Chairman of Medicine and Vice Dean at Drexel University School of Medicine. As an entrepreneur, Dr. Shulkin founded and served as Chairman and CEO of DoctorQuality, one of the first consumer-oriented sources of information on quality and safety in healthcare.

A board-certified internist, Dr. Shulkin is also a fellow of the American College of Physicians. He received his medical degree from the Medical College of Pennsylvania, and he completed his internship at Yale University School of Medicine and a residency and fellowship in General Medicine at the University of Pittsburgh Presbyterian Medical Center. He also received advanced training in outcomes research and economics as a Robert Wood Johnson Foundation Clinical Scholar at the University of Pennsylvania.

Dr. Shulkin has been named as one of the "50 Most Influential Physician Executives in the Country" by Modern Healthcare. He has also previously been named among the "One Hundred Most Influential People in American Healthcare." He has been married to his wife, Dr. Merle Bari, for 29 years. They are the parents of two grown children.

Updated February 2017

STATEMENT OF THE HONORABLE DAVID J. SHULKIN
SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES
BUDGET REQUEST AND PRIORITIES FOR FISCAL YEAR 2018
MAY 3, 2017

Good morning, Chairman Dent, Ranking Member Wasserman Schultz, and Distinguished Members of the House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies. Thank you for the opportunity to testify today in support of the President's 2018 Budget Blueprint and to define my priorities to continue the dynamic transformation within the Department of Veterans Affairs (VA). I also want to thank Congress for providing the Department its full 2017 budget prior to the start of the Fiscal Year – this is significant and has been extremely beneficial to our ability to provide services and care to Veterans. The 2018 budget request fulfills the President's strong commitment to all of our Nation's Veterans by providing the resources necessary for improving the care and support our Veterans have earned through sacrifice and service to our country.

Fiscal Year 2018 Budget Blueprint

The President's 2018 budget requests $78.9 billion in discretionary funding for VA, a $4.4 billion or 6 percent increase from the 2017 enacted level. The budget also requests $3.5 billion in mandatory budget authority in 2018 to continue further development and improvement of the Veterans Choice Program (the Choice Program). This budget request will ensure the Nation's Veterans receive high-quality health care and timely access to benefits and services. It provides a $4.6 billion increase, or 7 percent, in discretionary funding for VA health care to improve patient access and timeliness of medical care services for approximately 9 million enrolled Veterans. The funding would enable VA to provide a broad range of primary care, mental health care, specialized care, and related medical and social support services to enrolled Veterans, including services that are uniquely related to Veterans' health and special needs. I urge Congress to support and fully fund our 2018 request – the resources are critical to enabling the Department to meet the demonstrated needs of our Veterans.

Modernizing VA

As you all know, I was part of the VA team for the last year and a half prior to being confirmed as Secretary of Veterans Affairs. I came to VA during a time of crisis, when it was clear Veterans were not getting the timely access to high-quality health care they deserved. I soon discovered that years of ineffective systems and deficiencies in workplace culture led to these problems. I know that the organization

has made significant progress in improving care and services to Veterans. But I also know that VA needs more changes to the way we do business for Veterans and the country as a whole, in order for all to say, "That is a different organization now." VA needs to continue to fix numerous areas of the business, including access, claims and appeals processing, and many of our core functions, to ensure that the basics are done correctly. Beyond that, VA has to deliver to Veterans revolutionary leaps in care, benefits, and services. Congress, along with our VA employees, Veterans Service Organizations (VSO), and private industry, will play a critical role in making those revolutionary leaps a reality.

Focus on Execution

Above all else, VA needs to perform its core functions well. When Veterans arrive at a VA facility for care, they must be treated with respect, see a clean and modern facility, be seen by their provider on time, and understand what the next steps for their care will be. We must ensure that this is every Veteran's experience every time they interact with VA. Where we fall short, we will hold employees accountable, ensure we are good stewards of the taxpayer dollar, and ask for Congress's support for legislative fixes where needed.

Make Bold Change

We know it is paramount that we increase our focus and intensify the efforts to improve how we execute our mission – Veterans should and do expect that from us. We also recognize that incremental change is not sufficient to achieve the additional improvements VA and Veterans need and demand for restoring the trust of Veterans and the American public.

As I have noted, VA is a unique national resource that is worth saving, and I am committed to doing just that. Veterans have unique needs, and the services VA provides to Veterans often cannot be found in the private sector. The Veterans Health Administration (VHA) provides support to Veterans through peer support, crisis lines, transportation, the Caregivers program, homelessness services, vocational support, behavioral health integration, medication support, and a VA-wide electronic medical record system. These are unparalleled. We also know that, by the quality measures included in the government's Hospital Compare ranking system, VA hospitals in general outperform civilian hospitals in most categories. Compared with 4,010 non-VA hospitals, VA institutions had lower 30-day mortality and readmission rates in all categories, and exceeded the private sector in six of nine patient safety indicators, while matching the private sector in the other three. With the continued support from Congress, VA will supplement its services through private-sector health care, but we realize it is not a replacement for the services VA provides to Veterans.

We are already enacting bold changes in the agency. We are working hard to ensure employees are held accountable to the highest of standards and working with Congress to provide us with greater authority and flexibility to do that. We are also

working with Congress on appeals reform and on a long-term solution for providing greater community care options. I will discuss these efforts in greater detail below.

Five Priorities

As I prepared for my confirmation hearing earlier this year, I identified my top priorities to address as Secretary. These areas have shaped the first several months of my tenure and provide focus for our attention and resources, and the foundation for rebuilding trust with our Veterans. We will also use the budgeting process to support our strategy by shifting our resources toward our "foundational services" that make VA unique while maintaining support to our strategic priorities.

Priority 1: Greater Choice for Veterans

The Choice Program is a critical program that has increased access to care for millions of Veterans. Coming into this new administration, extending the Choice Program was one of my top priorities for quick action, as VA estimated that based on Veteran program participation; there would be an estimated $1.1 billion in unobligated funds left on the original expiration date of August 7, 2017. On April 19, 2017, the President signed into law the Veterans Choice Program Improvement Act (Public Law 115-26), allowing the Choice Program to continue until the Veterans Choice Fund is exhausted. Without this legislation, VA would have been unable to use funding specifically appropriated for the Choice Program by Congress, so we commend Congress for passing this legislation swiftly and in a bipartisan manner. This legislation also provides VA and Congress more time to develop a long-term solution for community care.

Since the start of the Choice Program, over 1.4 million Veterans have received Choice care. In FY 2015, VA issued more than 380,000 authorizations to Veterans through the Choice Program. In FY 2016, VA issued more than 2,000,000 authorizations to Veterans to receive care through the Choice Program, more than a fivefold increase in the number of authorizations from 2015 to 2016.

Looking at early data for 2017, it is expected that Veterans will benefit even more this year than last year from the Choice Program. In the first quarter of FY 2017, we have seen a more than 35 percent increase from the same period in FY 2016 in terms of the number of Choice authorizations (approximately 750,000). In addition to increasing the number of Veterans accessing care through the Choice Program, VA is working to increase the number of community providers available through the program. In April 2015, the Choice Program network included approximately 200,000 providers and facilities. As of February 2017, the Choice Program network had grown to over 400,000 providers and facilities, a more than 125 percent increase during this time period.

As these numbers demonstrate, demand for community care is high, and VA will continue to partner with Congress to develop a community care program that addresses the challenges we face in achieving our common goal of providing the best health care

and benefits we can for our Veterans. We have also worked with and received crucial input from Veterans, community providers, Veterans Service Organizations (VSO), and other stakeholders in the past, and we will continue doing so going forward. However, we do need your help.

One such area is in modernizing and consolidating community care. Veterans deserve better, and now is the time to get this right. We are committed to moving care into the community to where it makes sense for the Veteran. The ultimate judge of our success will be our Veterans, and our only measure of success will be our Veterans' satisfaction. With your help, we can continue to improve Veterans' care in both VA and the community.

Empower Veterans through Transparency of Information

We are also increasing transparency and empowering Veterans to make more informed decisions about their health care through our new Access and Quality Tool. This Tool allows Veterans to access the most transparent and easy to understand wait-time and quality-care measures across the health care industry. That means Veterans can quickly and easily compare access and quality measures across VA facilities and make informed choices about where, when, and how they receive their health care. Further, they will now be able to compare the quality of VA medical centers to local private sector hospitals. This Tool will take complex data and make it transparent to Veterans. This new Tool will continue to improve as we receive feedback from Veterans, employees, VSOs, Congress, and the media.

Priority 2: Modernizing our System

Infrastructure Improvements and Streamlining

In 2018, VA will focus on fixing VA's infrastructure while we transform our health care system to an integrated network to serve Veterans. As stated in VA's response to the Commission on Care recommendations, a strong suite of capital planning programs, tools, and resources are being developed to improve Veteran outcomes expected from implementing an integrated health care network. A national infrastructure realignment strategy will follow and be used to inform VA's capital planning efforts and develop a nationwide investment/divestiture plan.

Currently, VA is working towards the goal of high-performing networks that take into account current and expected future services by developing a structure to integrate community care and VA-provided health care on a market by market basis. The Department is working with private-sector health care experts to design an approach for integrated health care delivery decisions based on Veteran population, demand, internal capacity, and external public and private-sector health care resources and capacity. Once the approach is validated and piloted, a national infrastructure realignment strategy will be developed. Through this process, VA will also identify the resources,

tools, and authorities that are needed to enable the divestiture of assets and to streamline capital project execution.

The Department is also a key participant in the White House Infrastructure Initiative to explore additional ways to modernize and obtain needed upgrades to VA's real property portfolio, to support our continued delivery of quality care and services to our nation's Veterans. We are excited about the opportunity to transform the way we approach our infrastructure.

Electronic Health Record Interoperability and IT Modernization

VA recognizes that a Veteran's complete health history is critical to providing seamless, high-quality, integrated care, and benefits. Interoperability is the foundation of this capability, by making relevant clinical data available at the point of care and enabling clinicians to provide Veterans with prompt, effective care. Today, VHA, the Veterans Benefits Administration (VBA), and the Department of Defense (DoD) share more medical information than any public or private health care organization in the country. We have developed and deployed, in close collaboration with DoD, the Joint Legacy Viewer (JLV). JLV is available to all clinicians in every VA facility. It is a web-based user interface that provides clinicians with an intuitive display of DoD and VA health care data on a single screen. VA and DoD clinicians can use JLV to access the health records of Veterans, Active Duty, and Reserve Servicemembers from all VA, DoD, and any third party providers who participate in Health Information Exchanges where a patient has received care.

VA will complete the next iteration of the VistA Evolution Program, VistA 4, in 2018. VistA 4 will bring improvements in efficiency and interoperability, and will continue VistA's award-winning legacy of providing a safe, efficient health care platform for providers and Veterans. VistA Evolution funds have enabled investments in systems and infrastructure that support interoperability, networking and infrastructure sustainment, continuation of legacy systems, and efforts such as clinical terminology standardization. These investments are critical to the maintenance and deployment of the existing and future modernized VistA and essential to operational capability. Whether the path forward is to continue with VistA, shift to a commercial electronic health record (EHR) platform, or some combination of both, these investments will deliver value for Veterans and VA providers.

We are considering all options from adopting a commercial off the shelf (COTS) EHR to retaining an enhanced and standardized VistA. A decision will be made in July 2017, when the reviews are complete and all the pertinent information is available. The goal is to make a decision that will best serve Veterans' needs.

Priority 3: Focus Resources More Efficiently

Strengthening of Foundational Services in VA

VA is committed to providing the best access to care for Veterans. To deliver the full care spectrum as defined in VA's medical benefits package, VA will focus on its foundational services—those areas in which it can excel—and build community partnerships for complementary services. VA developed the following guiding principles, centered on improving the health, well-being, and experience of Veterans receiving care from VA and in the community. These principles include:

- Enabling VA to provide access to high-quality care for Veterans, by balancing services provided by VA and the community given changing demands for care and resource limitations;
- Promoting operational efficiency and simplicity, while supporting VA's clinical care, education, and research missions; and
- Allowing facilities to meet the changing needs of Veterans in a flexible way.

High-performing organizations cannot excel at every capability and thus must make decisions about how best to invest its resources. VA will therefore further define, and grow its foundational services, to excel in the provision of clinical care to Veterans.

Investing in foundational services within the Department is not limited to only health care. For over a decade, VA's National Cemetery Administration (NCA) has achieved the highest customer satisfaction rating of any organization – public or private – in the country. They achieved this designation through the American Customer Satisfaction Index six consecutive times. The President's 2018 Budget Blueprint recognizes the need to nurture and advance this unprecedented success. NCA's workload will continue to grow as the system expands. In 2018, NCA will inter approximately 133,600 Veterans and eligible family members, care for over 3.7 million gravesites, and maintain 9,400 acres. NCA will also continue to memorialize Veterans by providing 366,000 headstones and markers, distributing 702,000 Presidential Memorial Certificates and expanding the Veterans Legacy program to communities across the country. VA is committed to investing in NCA infrastructure, particularly to keep existing national cemeteries open and to construct new cemeteries resulting from burial policies approved by Congress. When all new cemeteries are opened, nearly 95 percent of the total Veteran population – about 20 million Veterans – will have access to a burial option in a Veterans' cemetery within a reasonable distance of their homes.

VA/DoD/Federal Coordination

VA has proposed legislation to eliminate certain statutory impediments to VA more effectively pursuing joint projects with other Federal agencies, including DoD. Today, medical facilities that are not specifically under the jurisdiction of the Secretary require specific statutory authorization for optimal collaboration. I look forward to working with Congress to: (1) enhance our ability to coordinate with DoD and other Federal agencies; (2) improve the access, quality, and cost effectiveness of direct

health care provided to Veterans, Servicemembers, and their beneficiaries; (3) permit joint capital asset planning and capital investments to design, construct, and utilize shared medical facilities; and (4) provide authority to transfer funds between VA and other Federal agencies for joint medical facility initiatives.

Deliver on Accountability and Effective Management Practices

Another critical area in which VA is serious about making significant changes relates to employee accountability. The vast majority of employees are dedicated to providing Veterans the care they have earned and deserve. It is unfortunate that certain employees have tarnished the reputation of VA and so many who have dedicated their lives to serving our nation's Veterans. We will not tolerate employees who deviate from VA's I-CARE values and underlying responsibility to provide the best level of care and services to them. We support Congress' ongoing efforts to provide VA with the tools it needs to take timely action against employees who perform poorly or engage in misconduct. Where employees engage in inappropriate behavior, do not perform the duties of their job, are engaged in illegal activities, or other situations where a person should no longer be a VA employee, we want the ability to ensure they can be promptly removed. Certain laws now on the books hamper our ability to optimally hold our employees accountable and remove those individuals that run afoul of my intent for the Department to function as a high-performing organization. We support legislation that is consistent with the following principles:

- Increase flexibility to remove, demote, or suspend VA employees for poor performance or misconduct;
- Provide authority to recoup bonuses of employees for poor performance or misconduct;
- Enable recovery of relocation expenses that occur through fraud or malfeasance; and
- ensure that VA has the ability to retain high performers by paying them a salary that is competitive with the private sector and performance awards that are commensurate with other federal agencies.

We thank the House for passing critical accountability legislation – but while that process continues, we are also focused on updating internal hiring practices. VHA is the largest health care system in the United States, and in an industry where there is a national shortage of health care providers, VHA faces competition with the commercial sector for scarce resources. Historically, VA has followed hiring practices that have proven unduly burdensome. Over the past year, VHA's business process improvement efforts have resulted in a more efficient hiring process. We were able to reduce the time it took to hire Medical Center Directors by 40 percent and obtained authority from the Office of Personnel Management (OPM) to provide critical pay to many of our senior health care leaders. We recognize there is much work left to do. As we strive to find internal solutions, we look forward to working together on legislation to reform recruitment and compensation practices to stay competitive with the private sector and other employers.

To ensure that VA's management practices are effective, I have announced a major initiative to improve our ability to detect and prevent fraud, waste, and abuse within VA. The initiative includes:

- forming a fraud, waste, and abuse advisory committee comprised of experts from the private sector and other government organizations; and
- identifying cutting edge tools and technologies available in the private sector.
- coordinating all fraud, waste, and abuse detection and reporting activities through a single office.

With these improvements, VA has the potential to save millions of taxpayer dollars and more effectively serve America's Veterans. I look forward to updating you in the future regarding this initiative.

Priority 4: Improve Timeliness of Services

Access to Care and Wait Times

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

In February 2017, 96.8 percent of appointments were within 30 days of the clinically indicated or Veteran's preferred date, and VHA has reduced the Electronic Wait List from 56,271 appointments to 22,840 appointments, a 59 percent reduction between June 2014 and March 2017.

Through the Choice Program, VHA and its contractors created more than 3.6 million authorizations for Veterans to receive care in the private sector from February 1, 2016, through January 31, 2017. This represents a 23 percent increase in authorizations when compared to the same period in 2015 and 2016. When looking at overall appointment data not specific to the Choice Program, the March 15, 2017, pending appointment data set shows VA has increased the number of overall pending appointments by nearly 1.8 million over the same data the prior year. According to that same data, the number of patients waiting greater than 30 days has decreased by 6.8 percent (35,325) since the beginning of FY 2017.

Accelerating Performance on Disability Claims

Since 2013, VA has made remarkable progress toward reducing the backlog of disability compensation claims pending over 125 days and is working to use more effectively the resources provided by Congress. VBA will increase staffing by 1.9 percent in 2017 to address its non-rating workload and completed 1.2 percent more rating work compared to the same time period the year before. In FY 2017, VBA is

reviewing and implementing new performance standards for its employees to reflect the increased productivity due to new processes and technological enhancements. In May 2016, VBA implemented the National Work Queue (NWQ). This allows VBA to prioritize and distribute claims according to capacity and as quickly as possible, regardless of the Veteran's place of residence. The NWQ process enabled VA to more effectively balance the workloads nationally, relative to the productive capacity at each regional office. This means that Veterans who live in a location where submissions have increased do not wait longer for decisions, solely because resources are not adjusted to match the changes in claims volume. In FY 2017, VBA added non-rating related claims to the NWQ. VBA has completed nearly 1.5 million non-rating claims through the end of March. The effort to address non-rating claims has resulted in dependency claims inventory falling 269,000 in August 2015 to less than 90,000.

To continue improving disability claim processing, VBA will begin implementing an initiative called Decision Ready Claims (DRC) this month. The DRC initiative is an expedited claims submission option available to Veterans who have elected VSOs and other accredited representatives to assist them with preparing and submitting their disability claims. Under the DRC initiative, VSOs assist Veterans with ensuring all supporting evidence is included with the claim at the time of submission. The DRC initiative empowers Veterans by allowing them to receive examinations as early as possible in the claims process.

This initiative will also enhance partnerships with VSOs by improving access and capabilities to assist with gathering all required evidence and information to accelerate claims decisions. Submission of claims submitted through the DRC process will result in claim decisions within 30 days of submission to VA.

Decisions on Appeals

The current VA appeals process undoubtedly needs further improvements for our Nation's Veterans. As of March 31, 2017, VA had 469,696 pending appeals. The average processing time for all appeals resolved by VA in FY 2016 was approximately 3 years. For those appeals that were decided by the Board of Veterans Appeals (the Board) in FY 2016, on average, Veterans waited at least 6 years from filing their Notice of Disagreement until the Board's in FY 2016. Without significant legislative reform to modernize the appeals process, Veteran wait times and the cost to taxpayers will only increase. Comprehensive legislative reform is necessary to replace the current lengthy, complex, confusing VA appeals process with a new appeals process that makes sense for Veterans, their advocates, VA, and other stakeholders. This reform is crucial to enable VA to provide the best service to Veterans and is one of my top priorities.

VA worked collaboratively with VSOs and other stakeholders to design this new process for Veterans who disagree with a VA decision. The result of that work was a legislative proposal that was introduced in the 114th Congress and has been reintroduced in the 115th Congress. The proposed process: (1) establishes multiple options for Veterans instead of the single option available today; (2) provides early resolution of disagreements and improved notice as to which option might be best; (3)

eliminates the inefficient churning of appeals that is inherent in the current process; (4) features quality feedback loops to VBA; and (5) improves transparency by clearly defining VBA as the claims agency and the Board as the appeals agency in VA. This clear definition between VBA and the Board also provides workload transparency for better workload/resource projections, and efficient use of resources for long-term savings.

The new process, described in the legislation currently pending, will provide a modernized process going forward. However, VA is also committed to reducing the pending inventory of legacy appeals. VA has worked collaboratively with stakeholders to identify opt-ins that would make the new process available to Veterans who would otherwise have an appeal in the legacy process. After assessing these various options, and collaborating with our partners, we have identified two opt-ins that we intend to implement, one statutory and one regulatory, to address the issue of the legacy appeals inventory.

The legislation must be enacted now to fix this process. It has wide stakeholder support and the longer we wait to enact this legislative reform, the more appeals will enter the current, broken system. The status quo is not acceptable for our Nation's Veterans. The new process will provide much needed comprehensive reform to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair.

Priority 5: Suicide Prevention – Getting to Zero

Every suicide is tragic, and regardless of the numbers or rates, one Veteran suicide is too many. Suicide prevention is VA's highest clinical priority, and we continue to spread the word throughout VA that "Suicide Prevention is Everyone's Business." VA recognizes that Veterans are at an increased risk for suicide and implemented a national suicide prevention strategy to address this crisis. VA is bringing the best minds in the public and private sectors together to determine the next steps in implementing the Getting to Zero Initiative. VA's suicide prevention program is based on a public health approach that is ongoing, utilizing universal, selective, indicated strategies while recognizing that suicide prevention requires ready access to high quality mental health services, supplemented by programs that address the risk for suicide directly. VA's strategy for suicide prevention requires ready access to high quality mental health (and other health care) services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high-risk patients.

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

support and pre-emptive enhanced care in order to lessen the likelihood that the challenges these Veterans face will become a crisis.

Other than Honorable Expansion

We know that 14 of the 20 Veterans who on average commit suicide each day did not for various reasons, receive care within VA. Our goal is to more effectively promote and provide care and assistance to such individuals to the maximum extent authorized by law. In that regard, VA intends to expand access to emergent mental health care for former Servicemembers, who separated from active duty with other than honorable (OTH) administrative discharges. This initiative specifically focuses on expanding access to former Servicemembers with OTH administrative discharges who are in mental health distress and may be at risk for suicide or other adverse behaviors. VA estimates there are more than 500,000 former Servicemembers with OTH administrative discharges. As part of this initiative, former Servicemembers with OTH administrative discharges who present to VA seeking mental health care in emergency circumstances for a condition the former Servicemember asserts is related to military service would be eligible for evaluation and treatment for their mental health condition. Such individuals may access the system for emergency mental health services by visiting a VA emergency room, outpatient clinic, Vet Center, or by calling the Veterans Crisis Line. Services may include: medication management/pharmacotherapy, lab work, case management, psycho-education, and psychotherapy.

Closing

Thank you for the opportunity to appear before you today to address our 2018 budget request and to provide you with the priorities that I am taking to ensure that VA is viewed with pride of services from our Veterans. I ask for your continued steadfast support in funding our full FY 2018 budget request and continued partnership in making bold changes to improve our ability to serve Veterans. I look forward to your questions.

Mr. DENT. Yes, at this time, I would like to recognize the chair of the full committee, Mr. Frelinghuysen, if he has any questions.

VISTA ELECTRONIC HEALTH RECORDS

The CHAIRMAN. Very briefly, you talk of the legacy system. The acronym is VistA. Now, you are looking at an off-the-shelf system.

Isn't the issue here you have different I.T. systems at every hospital? So, where are you in the overall—very briefly, where are you—in terms of some—maybe some good news in the mix?

Secretary SHULKIN. Right. Well, we only have 130 different systems, okay. So the VistA system is something that, frankly, VA should be proud of. VA invented it. It was the leader in electronic health records. But, frankly, that is old history, and we have to look at keeping up, and to modernize the system.

I have said two things, Mr. Chairman, in the past. I have said—number one is VA has to get out of the business of becoming a software developer. This is not our core competency. I don't see why it serves veterans. I think we are doing this in a way that, frankly, we can't keep up with.

So, I have said that we are going to get out of that business. We are either going to find a commercial company that will take over and support VistA, or we are going to go to an off-the-shelf product, and that is really what we are evaluating now. We have an RFI out for essentially the commercialization of VistA that we would no longer be doing internally.

The second thing I have said is that—and I think it was referenced in several of your comments—you have asked the Department of Defense and VA to work together probably for 10 or 15 years. And we have always found ways not to do that.

Secretary Mattis and I have talked about this. We believe that we need to find ways to work together.

So when I come out in July, I am going to be talking about a process that led to a decision to get us out of the software development business and to find a way to work even closer with the Department of Defense than we have. And we are working rapidly towards that decision, and I am committed to that date.

The CHAIRMAN. Thank you for that progress.

Mr. DENT. Thank you. At this time, I would like to recognize Mrs. Lowey.

Mrs. LOWEY. Thank you so much—thank you so much, Mr. Chairman. There are so many questions, but I must continue this discussion, having been part of this issue of records for the last 5, 6, 7 years.

And I gather we have spent $1.4 billion on this—I don't even know what I want to call it, project, search, interoperability. But what I am confused about, it is my understanding that the Defense Department has already rolled out the system.

It seems to me you make a lot of sense saying, we are not going to be in this business anymore, we want an off-the-shelf system. However, in order to foster—to ensure there is interoperability, what is wrong with the Defense program, and why wouldn't you, at least at the outset, explore that?

Because if you choose another system, and they have their system, what is it going to be? Another billion dollars that we could

use for suicide prevention, for treatment, for all kinds of important things.

I have to tell you, as the ranking member, Chairman Frelinghuysen and I go to a lot of committee hearings. But this affects my heart. And when I talk to veterans in the district, and I know the challenges they are facing, and I know that you have all the competence, background to do it, why wouldn't you start—or are you looking at the system the Defense Department has rolled out?

Secretary SHULKIN. Yes, so, first of all, I hear your——

Mrs. LOWEY. Frustration.

Secretary SHULKIN. That is probably a good word.

Mrs. LOWEY. I am smiling, so—we have had hearings where the anger was——

Secretary SHULKIN. Yes, yes. No, listen, Congress has been very clear on this for years and years. And that is why I believe that you and the American people and the veterans deserve a clear direction on this. And I am committed to doing that.

I can tell you we are exploring all options. I am sure you understand this is a highly complex issue. And I have lived through personal electronic medical record conversions in hospitals that I have led. These are not easy projects in single hospitals, let alone talk about the size of the VA system. So we are taking this very seriously. I can assure you we are exploring all those options.

We also as we get more veterans out into the community, out into the private sector hospitals, we have to be very concerned about interoperability with those partners as well. So if there was an easy solution here, I am sure it would have been made already. But we are going to make a decision and we are going to move forward with it, and we are going to need your help in being able to implement that.

Mrs. LOWEY. I just want to say thank you, Mr. Chairman. And I want to thank you for assuming the responsibilities that our veterans certainly are looking for and they deserve. And I wish you the best of luck. And I look forward to your coming back sooner rather than later, because I don't want to have another hearing on interoperability.

Secretary SHULKIN. Right.

Mrs. LOWEY. So thank—and I want to remind you again, $1.4 billion has already been spent on trying to get the Defense Department and the VA coordinated. So thank you so much again. We look forward to hearing from you as soon as possible.

Secretary SHULKIN. Thank you.

Mr. DENT. Thank you, Mrs. Lowey.

THE FUTURE OF COMMUNITY CARE

Mr. Secretary, we understand that you are floating ideas for a system to consolidate the various non-VA care programs, including Choice. While we realize your proposals are by no means locked down, it sounds like you are contemplating a plan that would allow veterans to seek urgent care outside the VA system. It will be followed by a discussion with a VA care provider about whether the veteran should be seen in the community or by the VA. That decision would be based on the results of a local health market anal-

ysis identifying the capacity, quality and cost of the various services at the local VA.

Is the basic premise of this proposal to keep services within the VA, subject to availability, quality and capacity, rather than open the doors more broadly to non-VA care?

Secretary SHULKIN. Let me try to describe it, Mr. Chairman, a little bit differently than that.

First of all, I think you are correct that what we have identified coming out of the 2014 wait-time crisis out of Phoenix was that the VA, I don't believe had the appropriate management systems in place. And the way I believe that you run a clinical system is that you put your clinical urgency first.

So, if somebody is waiting for a routine examination, that is normal. But somebody shouldn't be waiting if they have a tumor in their chest or if they have blood, you know, coming out of parts of their body that they shouldn't have it coming out of. That needs urgent care right away. So we are going to prioritize and to make sure that veterans aren't waiting.

Secondly, we are trying to build an integrated system of care. That means if you look at this from the veteran's perspective, which is really the only perspective we should be looking at this from, you want to take what the VA does best for veterans that you can't find as well in the private sector. And you want to take what the private sector does best that the VA doesn't do as well.

And you want to make that an integrated experience for the veteran. And that is what we are trying to do. Currently, one-third of our care happens outside the VA walls; two-thirds inside. And we are working now to get the proper mix in each of the communities, because it will look different in New York City than it will in Arkansas, and try to figure out in that community what is the proper mix of inside VA and working with the community. And that is what we are hard at work at doing. And I think that this will benefit the veteran the most.

Mr. DENT. And to follow up on that. What cost governors would you include to keep the program costs to a manageable level?

Secretary SHULKIN. Yes. Well, I am very sensitive to cost. And my belief is that one of the reasons why we got into the problems that we did in VA is because we were not properly funding the actual demand. And that is why I think it is so important that we, and you work with us, to get what the President has requested for the 2018 budget. Because I think that we need that.

But I am not looking for non-sustainable increases year after year the way that we have in the past. And I think as Congresswoman Wasserman Schultz said, that is an unsustainable solution. The problems that we have in the VA are not primarily financial. These are primarily system issues that we haven't kept up with and we haven't modernized.

So I am looking for an investment this year to help us modernize our systems. The I.T. system will be one example of where we need to come back, but I am not going to be seeking increases of this type in future years to come.

So, we do need to put cost mitigation strategies in place. One of the areas that we are focusing on that I have already announced is fraud, waste, and abuse. I think that there are huge opportuni-

ties to identify waste and abuse in the current system. There are not the proper safeguards in place. And we are going to be taking some aggressive actions to do that.

There are other cost mitigation strategies that I am seeking as part of Choice. One of them would be for the VA to be able to do value-based purchasing. The private sector has moved towards this where there are accountable care organizations to focus on quality and cost, and where you can purchase care based on the best value, which is cost over quality.

We don't have those tools in the VA. In fact, we are restricted from using that. We have to pay a flat Medicare fee schedule. So, I am seeking the same tools that the private sector has to be able to control costs and improve quality.

WORKFORCE AND FACILITY INFRASTRUCTURE NEEDS

Mr. DENT. And can I just quickly follow up? If Congress were to adopt your ideas, what would that mean for workforce and facility infrastructure needs?

Secretary SHULKIN. In this budget?

Mr. DENT. Yes.

Secretary SHULKIN. We are seeking the budget so that we can hire the proper health care professionals. We now have 45,000 clinical openings in the Veterans Health Administration, and another 4,000 openings outside of the Veterans Health Administration. So for a total of 49,300 employees that we are seeking.

I think that, frankly, the crisis that went through and the lack of good press, and so the impact on the morale of the workforce has really hurt us in recruiting. Of course, we had a hiring freeze in place up until April 12th. So we have fallen behind.

And, in particular, in my priority areas like mental health, I need 1,500 new mental health professionals to join the VA. So we are really prioritizing that right now and this budget would allow us to get up to that staff.

Mr. DENT. Thank you, Secretary Shulkin.

At this time, I would like to recognize the ranking member, Ms. Wasserman Schultz, for 5 minutes.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

First and foremost, I just wanted to suggest that, as a number of members have mentioned it, because the Secretary is limited to only speaking about the skinny budget, it would be incredibly helpful and important, once we have the President's budget released, for us to ask him to come back and hold a hearing on the actual, full budget request.

So, I would ask both the chair—both chairs—to please consider doing that, just so we can delve into a little bit more detail. Thank you.

VETERANS CHOICE PROGRAM

I want to focus on the Choice Program for a moment, because you have asked for an additional $3.5 billion, and we talked about it yesterday a little bit. But, you know, we recently extended, as you mentioned, the Choice Program past the August expiration date, and there was $950 million left in the Choice account.

So, in part, obviously, rather than letting that funding languish, and considering that there is still a need, that made a lot of sense. But, we did envision the Choice Program to be a temporary program initially.

My understanding, and correct me if I am wrong, was that it was really supposed to be a bridge for the VA to transition to the Community Care Program, until we could get the Community Care Program in a place where it is able to provide the kind of timely services that we need it to.

If that is not the case, then can you explain the differences between the two? And you have also proposed Choice 2.0. So we have Choice, Choice 2.0 and Community Care. I am not sure it would ultimately help us realize our goal of efficiency if we have three different programs in the private sector to help make sure we can meet the needs of our veterans.

Secretary SHULKIN. Right. I couldn't agree with you more. I am looking for one program. Three programs doesn't work. We now know, having two programs, that didn't work very well. We confused veterans.

We had two programs, Community Care and Choice. They had different rules. They put veterans at risk in their credit because some—some paid first dollar, and others didn't, and you had to call different numbers to use them. We are proposing a single program for Community Care.

As far as the intent of Congress for 3 years, look, Congress stepped up in a big way after the crisis when, basically, the country and Congress agreed that the current situation with veterans waiting for care was unacceptable.

VA did exactly what Congress asked us to do, which was to put into place additional options for veterans to get care in the community. And now, we are seeing those authorizations and appointments occurring in the community.

When I started at VA a little bit less than 2 years ago, we had 20 percent of our care in the community. Today, it is about 32 percent. So you can see we are expanding those options. I don't think there is any turning back from this.

So whether it was intended to be authorized for 3 years or not—you know, I know that is what the legislation said—I think what we have seen is veterans need that care. They are coming to VA to seek that care, and we need to continue to support that. That is my opinion. So the $3.5 billion that was built into the program is very much a needed resource for our veterans.

Ms. WASSERMAN SCHULTZ. And I understand, given that your goal is one program—are you analyzing which program, ultimately, would be phased out? Because we have a tendency to, instead of phasing out programs, because they have people with a vested interest in them, simply, you know——

Secretary SHULKIN. Yes.

Ms. WASSERMAN SCHULTZ [continuing]. Going along to get along, rather than rocking the boat. And so, if we are adding $3.5 billion to the Choice Program and it—you know, it had $950 million left, there have been challenges with the Choice Program, and confusion, and there are still challenges with the Community Care pro-

gram, in what direction is the VA thinking of going when we—and what is the timeline for ultimately——

Secretary SHULKIN. Right.

Ms. WASSERMAN SCHULTZ [continuing]. Phasing out one program and only having one?

Secretary SHULKIN. Right. Well, with almost certainty, I can tell you there will not be three programs, because the current Choice Program will run out of money by the end of this calendar year. So that program is going to go away, and should be through December of this year.

What we are hoping to do is to work with you so that we can introduce a Community Care funding program—the chairman referred to it as Choice 2.0—which is a program that makes sense for veterans, which is a single program that operates under one set of rules for how veterans get care in the community.

And that new legislation, which we believe needs to be introduced by late summer or early fall in order to make the timeline, would end up with a single program.

Ms. WASSERMAN SCHULTZ. So you would eventually envision phasing out Community Care with the advent of——

Secretary SHULKIN. Yes.

Ms. WASSERMAN SCHULTZ [continuing]. Choice 2.0. Thank you. I yield back.

Mr. DENT. Thank you.

At this time, I would like to recognize the gentleman from Florida, Mr. Rooney, for 5 minutes.

Mr. ROONEY. Thank you, Mr. Chairman. I would like to just sort of continue on, you know, the same line briefly, or just maybe make a statement that our chairman of the full committee, as well as Mrs. Lowey, Ms. Wasserman Schultz—pretty much everybody up here—agrees. We have been giving you all a lot of money.

And I have been on this committee with General Shinseki, who I served under at Fort Hood with Mr. McDonough. He was a military man, Mr. McDonough, you know, businessman, you are a doctor.

By the way, we have a lot in common. Even though I am from Florida, I grew up in Philadelphia. I have got a Pittsburgh connection, so I am rooting for you.

But you know—and you talked about working with General Mattis and trying to get this continuity of care, and we all talked about on the stump when we are, you know, down in our districts that if you are—if you put the uniform on and serve this country, we are going to take care of you. As you mentioned Lincoln, we often reference Washington, the country can measure itself by how it treats its veterans.

And one of the things that we say, from the time that you enlist or the time that you get commissioned to the time that you die, you will not be, you know, left out in the cold, we are going to take care of you.

And one of the things that people ask me about is, well—how—where does it fall through the cracks? And we often talk about how, even though we are giving you all the money that you need, that, you know, the difference between DOD and the VA is way too big.

And whether it is, you know, the electronic records or just the fact that you have to basically start all over when you leave the military and you PCS and you get into the veterans, you know, program—whatever it is.

INTEROPERABILITY WITH DEPARTMENT OF DEFENSE

I guess my first question to you is, if General Mattis has a better idea than you do, will you agree to go to his program just to get this moving? I ask you this just to get this moving. I ask you this for this reason: you could be the best VA secretary of all time if you solve this one problem.

And I mean, every time we sit up here and talk to people at this table, that—we always keep asking the same question. And I know that there is a lot of bureaucracy, and I know there is a lot of pride, and whatever the problem is, but, you know, we just hope that this—if it means you saying to Mattis, "you know what, you are right, you have a better program, we are going to go with your program," will you do it?

Secretary SHULKIN. Yes. First of all, thank you for your comments, and I appreciate your perspective on this issue and how important it is.

I am only here for one reason, and that is to solve the problems that have plagued VA I wish it was only one problem, by the way. But I agree with you, this is certainly an important problem for us.

Anybody, whether it is Secretary Mattis or anyone else who has a better idea than I have, I am going to take it. The answer to your question is yes. We want to resolve this issue in the best way, and if it means taking somebody else's idea, we are going to do that.

Mr. ROONEY. I mean, it would be so good to be able to go home and stand up on the stump and tell these guys, I come from a district with a lot of retirees in Florida, a lot of military retirees—and tell these guys, "if you put on the uniform of this country, we are going to take care of you."

Basically, if you need the health or the mental health after you serve, it is—one of the advantages of joining, is that you know that you are going to be taken care of when you get out. So, that would be a huge help to all of us up here who are trying to convince people that fighting for this country has benefits well beyond just, you know, the pride of service.

TRANSITIONING CARE BETWEEN VA FACILITIES

One quick thing, since I am running out of time, and this is more specific to my district. I am having—my constituent services representatives down in Florida are telling me that we are getting a lot of people that are moving to Florida, as they always do, from other parts of the country.

And they are going in to get care at our VA, and because of whatever breakdown in coverage, they are told that in my district, that—they are told to start a new treatment plan or return to the State—to where they came from, where they were already getting care for whatever problems that they were having.

And this is kind of absurd from the standpoint of that I—we have actually got five or six specific cases where people that live in Florida can't get the care that they were getting in their other

State, so they are actually, rather than starting over in Florida, going back to their State where they came from and using that VA, because they are already in that system.

This, again, gets to that system where there shouldn't be any lapse in coverage, but there is. Can you talk about the—have you heard about this at all, or?

Secretary SHULKIN. I haven't heard about your specific situations, but I hope your directors are watching this right now, because what you described is unacceptable. We have one VA system. Veterans should be able to get care at any VA that they go into, and that is our commitment.

I am not at all doubting that it doesn't work all the time. I certainly hear many examples where it does work, and people are able to get care—they are travelling, they lose their medications, they are able to get to a VA, get them refilled, get the care they need. That is the system that we are—that is our expectation of how we manage the system, and I will reclarify that to our field.

[The information follows:]

One of the many advantages to our Veterans is the seamless care that we can provide throughout all of our VA facilities and this is possible through our national electronic record. All facilities need to make sure that front line staff offer a consistent message that no matter what type of services the Veterans are seeking, the site at which they are presenting has immediate access to their VA healthcare record.

The Office of Primary Care Operations will be confirming this expectation with field facilities during either the next Primary Care VISN Point of Contact call (May 18, 2017 at 1:00 pm EDT) and/or the Primary Care Interactive Office Hours (May 22, 2017 at 1:30 pm EDT).

Mr. ROONEY. Thanks, Doctor. Good luck.

Secretary SHULKIN. Thank you.

JOINT LEGACY VIEWER (JLV)

Mr. DENT. Thank you, Mr. Rooney. Mr. Secretary, if I could just interject on that point for a moment, could you just describe the current Joint Legacy Viewer——

Secretary SHULKIN. Yes.

Mr. DENT [continuing]. And what it can do to share DOD and VA records, just for the benefit of some of the members?

Secretary SHULKIN. Right.

Mr. DENT. And we will go to Mr. Bishop.

Secretary SHULKIN. Yes, and I am sorry—I am sorry that Congresswoman Lowey left for this, because I didn't say this to her, but we did certify interoperability with the Department of Defense in April of 2016. That is through the Joint Legacy Viewer, that is probably where a lot of her $1.4 billion went to, although I don't think it was that much.

And what this does is this allows any VA clinician, any DOD clinician, to be able to access records from the other system. So it is a read-only system. It is being used tens of thousands of times a month by our clinicians in both systems.

So, it does work and it is a lot better than before, when we didn't have that ability. It is better care. But it is not the complete interoperability that I think that all of us would hope for. It is a read-only system at this point.

Mr. DENT. Thank you for that clarification.

Now, Mr. Bishop.

Mr. BISHOP. Thank you very much, and welcome, Mr. Secretary. And let me join my colleagues in congratulating you and thanking you for your commitment to get these problems fixed.

THIRD-PARTY BILLING

Let me go to an area of improving timeliness of service, which is third-party, uncollected billing. The fiscal year 2016 report on the appropriations had directed the VA to submit an annual report identifying the amount of third-party health billings that are owed to the VA, and the annual amount that is collected.

It additionally required that the VA include a plan to capture uncollected third-party billings. The VA was directed to initiate a pilot program and figure out how best to capture the uncollected billings. The difference between billings and collections in fiscal year 2015 was $4.7 billion. And in fiscal year 2016, it was $5.164 billion.

This is alarming because it means that billions in uncollected dollars are not available to the VHA to provide the services to veterans. What is the status of the pilot program, and who in the department is responsible for the fiscal management of third-party billings and collections? And if you could answer that quickly——

Secretary SHULKIN. Yes, thank you.

Mr. BISHOP [continuing]. I want to move to another area.

Secretary SHULKIN. Congressman, I will try to answer this quickly.

I think you have identified an area of significant risk for us, that we have opportunity to do this in a much better way than we are currently doing this, so I think you are correct.

We currently collect around $3.4 billion a year. We actually will be asking for, in our new Choice legislation we hope to work with you on, the ability to do this better.

We, right now, are not allowed to require that veterans give us their other health insurance. So a lot of that gap right there is because we don't know their insurance numbers, and we don't know their insurance company from which to collect it.

But we are looking at—and we have a RFP that will be released in the next couple of weeks, to be able to see whether the private sector can actually help us do collections better, and that is part of our pilot work that we are doing. We are actually using another federal agency to help us with these collections, and that does seem promising.

So, I can get you a more detailed answer, because I don't want to take up the time now, about the results of the pilot project.

[The information follows:]

The FY16 MilCon/VA Approps bill required implementing a pilot program on third party fee collection opportunities.

The Veterans Access, Choice and Accountability Act of 2014 contained several independent assessments and recommendations from non-governmental entities with substantial private sector revenue cycle management experience. This extensive assessment of revenue operations recognized several achievements, however also provided valuable insight into opportunities for continued improvement. The outcome of the independent assessments is being used to form the basis of pilots to transform revenue collections for VHA.

VHA Office of Community Care Revenue Operations utilized the findings from the report to categorize improvement opportunities that could be addressed both internally and externally. To explore best practice solutions, an industry day was conducted for vendors to propose customized improvement programs for VHA. VHA Office of Community Care Revenue Operations is currently evaluating vendor solutions for implementation to support areas highlighted in the independent assessments.

The VHA Office of Community Care also leveraged the findings and recommendations from the Independent Assessment Section 201 to launch Revenue Operations Transformation Teams in February of 2017. These portfolio teams are focused on the development of process improvement initiatives and operational pilots targeting collections enhancement within the following areas of VHA's revenue cycle:

- **Registration** – collection of insurance cards and pre-registration activities
- **Clinical Documentation** – accurate and timely completion of clinical notes
- **Coding** – accurate and timely coding of billable encounters
- **Charge Capture** – consistent capture and receipt of charges
- **Billing & Collections** - efficient and precise billing & collection for services
- **Denials** – minimized denials and optimized recoveries

To ensure collaborative solutions, portfolios are comprised of representation from Revenue Operations and facilities, to include: HIM, VISNs, providers and administrative staff. The overall approach is to rapidly deliver solutions across 120 day sprints. The Revenue Operations Transformation teams are currently in Sprint 1 which concludes at the end May. Sprint 2 will begin immediately afterwards and continue for another 120 days.

VHA offers the additional context for 3rd party billing and collections:

VHA is authorized to bill and collect from Third Party (TP) insurance plans for Non-Service-Connected (NSC) services. Many unique policies and regulations govern the billing and collection activities of VHA in order to provide additional benefits to Veterans:

– VHA does not bill CMS (State Medicaid Programs, Medicare, Medicare Advantage plans)

– VHA does not collect patient cost shares and out-of-pocket costs associated with health plans

– VHA bills health plans for NSC services and does not bill the Veteran for any remaining balance after the health plan reimbursement is applied

In FY2016, VHA billed $7.9B to Third Party (TP) Payers, of the total billings, 2.30% remained active as of January 2017. Insurance plans are only obligated to reimburse VA up to their allowable charge minus patient cost sharing which VA is not authorized to collect.

VHA Office of Community Care Revenue Operations CPACs employs internal processes to review variances in payments to ensure VHA is being reimbursed appropriately. The Accounts Management departments within each CPAC monitor payment variances and conduct a formal denials management review process to improve efficiency and effectiveness of VHA billings and collections.

In FY2016 VA collected approximately 92% of the allowed amounts from Third Party payers.

Mr. BISHOP. Thank you very much and I look forward to that.
Secretary SHULKIN. Yes.

MYVA INITIATIVE AND VISN REALIGNMENT

Mr. BISHOP. Mr. Secretary, your predecessor, Mr. McDonald, started an initiative known as MyVA, to modernize and reorient the VA. The MyVA vision was to provide a seamless, unified veteran experience across the entire organization and throughout the country.

In your testimony, you mention that you intend to modernize the VA as well. Can you tell us how your plan differs from Mr. McDonald's, and how you plan to—and whether or not you plan to build upon the MyVA? And, can you also provide an update of the Veterans Integrated Service Network's realignment? That is the first part of the question.

And then the other has to do with facility realignment. You mention an actual infrastructure realignment strategy, and the last time VA made a major effort to set infrastructure needs was the Capital Asset Realignment for Enhanced Services, the CARES project. Do you envision that the department will embark on a similar effort?

And if so, when will we see a plan to invest and divest VA capital assets? Is the strategy that you plan to propose similar to the military base realignment—the BRAC process?

Secretary SHULKIN. Yep. Well, there is a lot there, Congressman, so I will try to do this quickly.

The MyVA program under Secretary McDonald, I think, no doubt, has the correct intent, which is to design a veteran-centric experience, and to focus on that experience. And we know that there was significant and good improvement being done under that program, because we could measure it.

What I have said to the Department is that one of the benefits of me having been in the Department under Secretary McDonald is that I already know what was working. And I don't want to stop the progress that was being made.

But I also don't believe we were making progress fast enough. So I am looking to essentially continue the parts of that program that work. But I am seeking much broader, bolder transformation of this Department because I think it is what is needed. And that is why I have sent my five priorities forward.

In terms of the VISN realignment, we used to have 21 VISNs. We are now down to 18. Whether 18 is the right number or not, I think we are always continuing to take a look at that.

But we are going to change the role and function of the VISN from what it currently is, which is another layer of administrative complexity—some people may call that red tape—to a much more profound function in managing their local markets and moving toward this value-based purchasing concept and making sure that veterans get the best of care in the community and the best in VA care.

So we are working on that transformation as we are building our Choice Program.

FACILITY REALIGNMENT

The realignment—the CARES program, I wasn't here when that was implemented. I do know that we have closed 1,000 facilities, so that—there has been progress made in that in the past. But I don't believe I have heard anybody, with enthusiasm, bringing back the CARES model. I think that we learned a lot of lessons in that.

Whether they are—whether the BRAC is a model that we should take a look at, we are beginning to have discussions with members of Congress about their suggestions. We do believe that we have, I know, today, 431 vacant buildings and 735 underutilized buildings.

And we want to stop supporting our maintenance of buildings we don't need, and we want to reinvest that in the buildings that we know have capital needs. So we are going to be looking forward to working with you on that.

Mr. BISHOP. Thank you very much, Mr. Secretary.

Mr. DENT. Mr. Womack.

Mr. WOMACK. Thank you.

FOCUS ON CORE COMPETENCIES

Mr. Secretary, welcome. And thanks for the breakfast yesterday and the opportunity to engage you in conversation before this hearing.

It has been my experience, down through the years, that organizations—particularly large organizations—that find themselves in a bit of trouble sometimes, and many—many times, stem from the fact that they get away from their core competencies and they expand into areas where they are not terribly knowledgeable, capable and certainly not efficient.

And they sometimes serve as kind of a weight, an albatross, if you will, around the neck of the organization, and it causes a lot of other things to be compromised in the process. And I suspect that the VA probably fits into this category.

And so, specifically, my question is this: you have spent some time talking about I.T., which, I am beginning to believe, is not a core competency of the VA. We have had many indications that the construction of property is not—Aurora, Colorado, being, probably, the poster child for it recently—not a core competency.

And you talked about collections just a moment ago. And that would not necessarily be a core competency.

So I am going to throw this on the table and let you respond. Is it your intent as the Secretary of VA to protect the core competencies of the VA by outsourcing, for lack of a better term, some of the other things that have served to kind of bog down the system?

Secretary SHULKIN. I think your assessment of what has happened in VA is probably pretty accurate. I think that we have learned the hard way and taken too long to make decisions in areas that, frankly, we just don't deserve to be in that business. And I think you have identified a few.

My only modification, if you wouldn't mind, on the I.T. is I think I.T. has to be a competency of any organization nowadays. I mean, I can't imagine not. What we don't want to be doing is being in the

software and product development business. But managing I.T. systems does need to be a competency of any successful company today, I believe.

I don't know whether "outsourcing" is the right word. I do believe that, if we are going to serve veterans, we need to be working with a core group of our employees and staff that functions on our core functions.

But when we have strayed outside, building buildings, you know, doing software development, doing—you know, claims and billing, I do think that we should be looking toward private-sector solutions, or, at the very minimum, private-sector—private-public partnerships where we can get the competencies into the Federal Government.

PREDICTING FUTURE DEMAND

Mr. WOMACK. The last question I have is that one of the problems facing the Congress, and many previous Congresses, is the fact that the entitlement programs that we know, the mandatory side of spending, continue to chew up available revenues, and—putting a lot of downward pressure on the discretionary piece of the budget. And that is getting worse and not better.

And I think part of that is because—and this is good news—the people are living longer. They are receiving benefits from those systems for a lot longer period of time than, actuarially, they were expected to at the time.

Do we have a pretty good handle on the number of people that will be entering the VA system, so that we can rightsize the funding request to ensure that we meet those needs, and not play from a position of weakness by being behind?

I have only got about 45 seconds left. But can you help me have confidence in knowing that we know what is going to be filling that pipeline, say, over the next generation?

Secretary SHULKIN. We certainly have a handle on the demographics of the veteran population. As you know, we have 22 million veterans today. And that is expected to decline.

What we can't predict is, obviously, new conflicts that would happen, because that can change the picture. What we can't predict is new science that would show that there is additional mandatory coverage that we would need to include, as science shows that there is a connection between military service and some of the disabilities. And that work is always ongoing.

So I think that we do have actuarial models in health care, cemeteries, and benefits that we can share some of the parameters for needs. But they are not fully accurate because of the unknowns that are out there. So—but I think, for what you are asking, we can share that with you.

Mr. WOMACK. Thank you for your service, and congratulations on your appointment.

I yield back.

Secretary SHULKIN. Thank you.

Mr. DENT. Thank you, Mr. Womack.

I would like to recognize Ms. Lee for 5 minutes.

Ms. LEE. Thank you.

Thank you. Good to see you, Mr. Secretary.

Secretary SHULKIN. Good to see you.

Ms. LEE. I, too, want to congratulate you and just say I am glad you are at the helm of the VA, say—and thank you for being here.

Secretary SHULKIN. Thank you.

OAKLAND REGIONAL OFFICE

Ms. LEE. A couple of questions, and I will try to ask them very quickly. One is relating to the Oakland VA Regional Office.

In January of 2014, the OIG found that there were significant delays, of course, in processing the claims. And the management didn't provide the oversight needed to ensure timely and accurate processing of informal claims. We had about 1,248 informal claims. Now, this was before the National Work Queue.

Now we are on the National Work Queue. And, I would like to find out, has this helped reduce the claims backlog significantly? And is it helping to streamline and reform benefit claims processing, specifically regarding the Oakland VA Regional Office? That is the first question.

HEALTH DISPARITIES AMONG MINORITY VETERANS

Second question has to do with what we have briefly discussed as it relates to minority veterans. I have looked at your health disparities report, which is a very thorough report. And, of course, it cited the fact that minority veterans were diagnosed with PTSD at rates higher than white veterans.

Also in the report, you go into some of the recommendations to begin to address not only PTSD in terms of its disparity, but all of the others. And it says that we need more research and more information.

And I am wondering, though, as it relates to this report and the recommendations, as it—specifically relating health disparities with minority veterans, where are we on any of it? And are the recommendations being followed up?

I can't help but wonder why more research would be needed. We have an Office of Minority Health over at HHS. And so I am not sure if you are coordinating, in terms of health disparities, with Health and Human Services.

Just exactly what is going on? Because this is, I think, a very good report. And I know many, many minority veterans who are really struggling with all of the issues around health care, especially PTSD.

And finally—and I have asked this of the OIG, and also when we were at the VA hospital—in terms of the utilization of minority and women-owned businesses, it is my understanding that you don't disaggregate the data.

I would like to find out how we are doing as it relates to African-American, Hispanic and Asia/Pacific American—Islander firms and companies. And we—I still haven't been able to drill down and get that report. The VA is a significant entity that contracts quite a bit of money out.

And I would like to find out how minority-owned contractors are faring. But we need to understand what the data is showing so that we can do better, because I have had a lot of complaints

that—from minority-owned businesses that they can't seem to penetrate and get into the system for a fair shot.

Secretary SHULKIN. Okay. Well, thank you, Congresswoman Lee.

These are all really important issues. So, on the claims backlog and what the impact of the National Work Queue has been, we do believe that that has been helpful. And we are seeing improvements in productivity.

I would like to get back to, for the record if it is okay, the impact from where you were measuring it at 1,248, in Oakland, and see where we are today so that we can track that progress together, because I think that is important.

[The information follows:]

APRIL FY17

Director	Regional Office
Vacant, Acting Director- Michele Kwok	Oakland

Monthly compensation and pension payments

Gross Amount	Veterans and their Beneficiaries
$192,927,818	152,968

Inventory

RO	Peak Inventory Date	Peak at	Inventory as of Report Date	Change Since Peak
343V	March, 2012	34,834	11,259	-67.7%

Backlog

RO	Peak Backlog Date	Peak At	Backlog as of Report Date	Change Since Peak
343V	June, 2012	30,008	3,306	-89.0%

Quality
3-month claims-based accuracy

RO	Month of Lowest Claims-Based In	Lowest Claims-Based Accuracy Amount	Accuracy as of Report Date	Change in Claims-Based Accuracy
343V	June, 2016	71.31%	82.54%	11.23%

Quality
3-month issue-based accuracy

RO	Month of Lowest Issue-Based In	Lowest Issue-Based Accuracy Amount	Accuracy as of Report Date	Change in Issue-Based Accuracy
343V	September, 2014	88.97%	94.07%	5.10%

Average Days to Complete (ADC) -FYTD

RO	Peak ADC Date	Peak ADC	ADC FYTD as of Report Date	ADC FYTD Change in Days Since Peak
343V	April, 2013	476.4	139.9	-336.5

Average Days to Complete (ADC) -MTD

RO	Peak MTD ADC Date	Peak ADC MTD	ADC MTD as of Report Date	ADC MTD Change in Days Since Peak
343V	October, 2012	502.2	129.7	-372.5

Average Days Pending (ADP)

RO	Peak ADP Date	Peak ADP	As of Report Date	Change in Number of Days Since Peak
343V	March, 2013	467.0	103.8	-363.2

Completed

RO	Claims Completed During FY14	Claims Completed During FY15	Claims Completed During FY16	Claims Completed through Report Date During FY17
343V	29,132	39,053	32,382	19,996

RO Total Over 1 Year Old Claims

RO	Peak Claims Older than 1 Year Old Pending Date	Peak Claims Pending	Remaining Claims as of Report Date	Change in RO Total Over 1 Year Old Claims Since Peak
343V	April, 2013	19,086	209	-98.9%

Fully Developed Claims(FDC)

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
343	24.5%	39.6%	57.6%	62.3%	64.4%

Non-Rating Claims

RO	Pending Non-Rating Claims as of Report Date	Prior FY Completed Non-Rating Claims through Report Date EOM	Current FY Completed Non-Rating Claims through Report Date EOM	EOM Non-Rating Claims Percent Change
343V	24,965	34,167	37,217	8.9%

Dependency Claims

RO	Pending Dependency Claims as of Report Date	Prior FY Completed Dependency Claims through Report Date EOM	Current FY Completed Dependency Claims through Report Date EOM	EOM Dependency Percent Change
343V	1,827	7,342	5,319	-27.6%

Appeals

RO	Appeals Pending as of Report Date	Prior FY Average Appeals Resolution Time through Report Date EOM (days)	Current FY Average Appeals Resolution Time through Report Date EOM (days)	EOM Appeals Percent Change
343V	6,792	1,066	986	-7.54%

Please Note

V- Veteran Service Center (VSC)
D- Integrated Disability Evaluation System (IDES)
P- Pension Management Center (PMC)
F- Foreign
B- Benefits Delivery at Discharge (BDD)
Q- Quick Start (QS)
R- Radiation (RAD)
C- Camp Lejeune Contaminated Water (CLCW)
L- Restricted Access Claim Center (RACC)

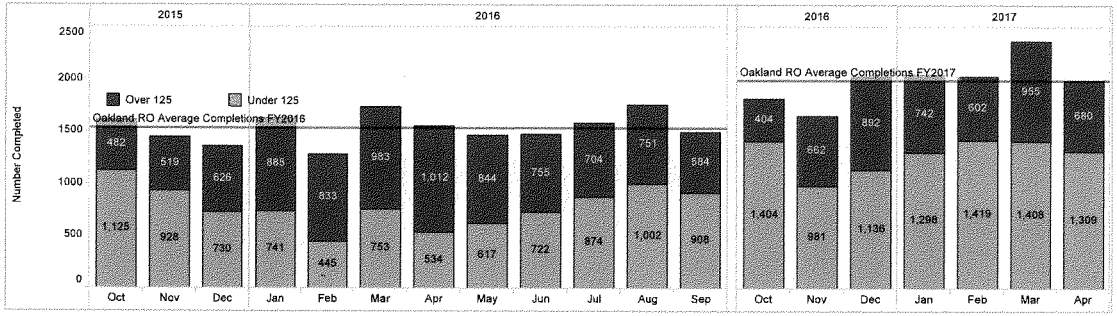
Oakland VA Regional Office Pre & Post NWQ Comparison

04/30/2017

Completed Rating Claims & Director Targets for Oakland RO

	2015			2016									2017						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Production	**1,607**	**1,447**	**1,356**	**1,626**	**1,278**	**1,737**	**1,546**	**1,461**	**1,477**	**1,578**	**1,753**	**1,492**	**1,808**	**1,643**	**2,028**	**2,040**	**2,021**	**2,363**	**1,989**

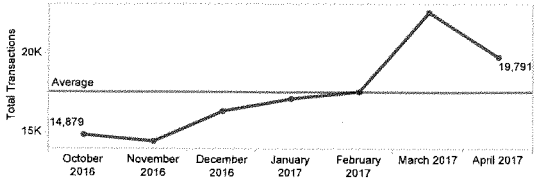
Completed Claims & Backlog Focus for Oakland VARO



California Veteran Highlights

	Pre-NWQ (avg)	Post-NWQ (avg)
Avg Days California Claims Wait Initial Development	17.4	10.1
Avg Days California Claims Wait Decision	27.8	6.9

FY2017 Oakland RO Transactions



% of California Claims in Oakland VARO (Pre-NWQ)

Oakland VARO	73.40%
Rest of Nation	26.60%

% of California Claims in Oakland VARO (Post-NWQ)

In NWQ	65.40%
Oakland VARO	3.60%
Rest of Nation	31.00%

On the health disparities report, I agree with you. I think the work that our national center is doing has identified significant issues. This, of course, is an example where I think VA is actually leading, and addressing issues that are important for all of the American public.

And in health care, we know that disparities are a very significant issue, particularly in many of our geographies across the country. I think VA is leading in this area, but we still have additional work to do. And we are treating this as a priority issue and looking at the recommendations you have talked about.

The research that the report recommended I think, is research on disparities in veterans. VA research has significant health services research components to it. And the difference between the health services research in VA and in HHS, like in the Agency for Healthcare Research and Quality, is our research is specific to veterans.

And so, we do believe that there are some questions that are important to ask in order to understand what the most effective interventions are. But I don't think that is a reason for us not to be implementing the other recommendations. There is important work to be done. And we are focused on this now.

Ms. LEE. Mr. Secretary, yes.

Secretary SHULKIN. Yes.

Ms. LEE. Let me just comment on that, because I know the research is very important. But I know, specifically, and when you look at African-American veterans with PTSD, you have got other factors that weigh in. And the Office of Minority Health could let you know what those external socio-determiners——

Secretary SHULKIN. Yes.

Ms. LEE [continuing]. Are.

Secretary SHULKIN. Yes.

Ms. LEE. It would really weigh in to help come up with treatment modalities that make more sense right away.

Secretary SHULKIN. Yes. I completely agree.

The research that we—research is only good if you act on it. And there are some things that we already know. And I think that this is where we are looking at this in terms of implementing the recommendations that we know need to happen. And it is a way that, frankly, VA can lead and help the rest of American health care also implement these interventions.

Ms. LEE. Do you have a working group that——

Secretary SHULKIN. We do.

Ms. LEE [continuing]. You put together?

Secretary SHULKIN. Yes.

Ms. LEE. I would like to talk to you a little bit more——

Secretary SHULKIN. Great. Great.

Ms. LEE [continuing]. On that. Thank you.

Thank you, Secretary——

Secretary SHULKIN. And then on the small businesses, on the minority—I don't know how that data can be essentially categorized to answer your questions. Let me, please, look into that and get back to you on that.

[CLERK'S NOTE.—The Department of Veterans Affairs was unable to provide a response to the question, despite having had 120 days to produce it.]

Ms. LEE. Okay. Thank you.

Thank you, Mr. Chairman.

Mr. DENT. Thank you.

Ms. LEE. Thanks. Good seeing you.

Mr. DENT. I would like to recognize the gentleman from California, Mr. Valadao, for 5 minutes.

Mr. VALADAO. Thank you, Chairman.

BLUE WATER NAVY VETERANS ACT

Thank you, Mr. Secretary.

As I am sure you are aware, in 2002, the VA reinterpreted the language of the Agent Orange Act of 1991 to apply only to veterans who actually set foot in the Republic of Vietnam or served in the inland rivers of Vietnam, or Brown Water veterans.

Veterans who served on ships, or Blue Water veterans, were not included, and must prove service connection and exposure to Agent Orange. However, proven exposure for Blue Water veterans is nearly impossible due to a lack of record-keeping and inability to know the precise location of the dioxins—in this case, Agent Orange—in the air or water runoff.

The VA continues to deny claims for Blue Water Navy veterans, despite studies showing higher rates of cancer and non-Hodgkin's lymphoma among shipboard veterans than those who fought on the ground in the country.

This year I introduced legislation to right this wrong, H.R. 299, the Blue Water Navy Veterans Act, which currently has over 270 bipartisan cosponsors, including over half of this distinguished subcommittee.

While I stand ready to work with my colleagues to pass this bill, the Department of Veterans Affairs has the power to right this wrong itself, without the help of Congress.

Have you been made aware of this issue since you have taken over as Secretary? And to your knowledge, is the VA working towards a solution on this issue?

Secretary SHULKIN. Thank you for that question.

Yes, I have been made aware of this issue. I would say 20 percent of my in-box is on this issue, so I hear from a lot of people. What I have done is, I have actually sat down and I have met with some of the leaders in this Blue Water Navy movement to understand exactly what they believe the science shows and what they are recommending.

Commander Wells is certainly one of them; John Rossi, another that I have recently met with in my office. They have followed up with additional information which I really appreciated because I am trying to bring myself up to speed on this. The VA's position on this has been pretty much the science isn't there.

I am not convinced that is the full story. And so, I have asked them for additional information and additional recommendations so that as you said if the Department of Veterans Affairs has the ability, and I agree with you, to change some of these, and if the evi-

dence suggests that that is the right thing to do for veterans, I am going to recommend that.

So this is very active. I can tell you this week alone I have been reviewing additional studies. So I will be, you know, certainly willing to engage in further conversation with you and I am aware of your legislation.

Mr. VALADAO. Thank you. And I do appreciate the fact that you acknowledge that there is other science out there. Because there are some studies out there that, especially with the way they treat the water, clean the water, that actually says it concentrates the chemicals and makes the situation worse for those serving.

Secretary SHULKIN. Yes.

NEW THERAPIES FOR PTSD

Mr. VALADAO. And I appreciate you bringing that up.

Then Mr. Secretary, I also understand that the Air Force is conducting clinical human trials at Tinker Air Force Base to investigate transcranial magnetic E-resonance therapy, MERT, on veterans suffering from PTSD and TBI, traumatic brain injury. After four weeks of active treatment, compared to the baseline, the treatment reduced an average PCLM score from 66 to 37.

The Air Force concluded that the preliminary results suggest that MERT is a promising treatment modality to help veterans suffering from PTSD. With this information can you please share with the committee what the VA is doing to capitalize on this promising new treatment to address PTSD in the veteran community?

Secretary SHULKIN. Well, I am very familiar with the—with the MERT technology and I am very concerned about finding new therapies that help our veterans with PTSD, as well as other conditions related to the brain. We do use—VA has extensive use already of transcranial magnetic stimulation. The issue is whether the MERT technology adds additional value to what we are currently using.

I have recently, in the last 10 days, visited Walter Reed. I have talked to them about this. We are looking at the science. I would like to see the results of the Air Force studies as they are coming on-line because basically if there is evidence in science suggesting that this is helpful and effective and especially a non-invasive technology, we absolutely want to be using it.

Today, I am not aware of evidence that suggests that MERT adds advantages in terms of scientific advantages, over the transcranial magnetic stimulation that VA and Walter Reed and others are using, and I have talked to my DOD colleagues. Now, with new information coming out of the Air Force, I would be very open to seeing that.

Mr. VALADAO. All right. Well, thank you again.

Thanks, Chairman.

Mr. DENT. Thank you, Mr. Valadao.

At this time I would like to recognize the gentleman from West Virginia for 5 minutes, Mr. Jenkins.

Mr. JENKINS. Thank you, Mr. Chairman.

Mr. Secretary, thank you also for the opportunity to visit with you in advance of this meeting to talk about your leadership and direction, and I applaud your efforts.

ACCESS AND QUALITY WEBSITE

Let me start off with a word of compliment. I learned yesterday from the discussion with you about your push to provide transparency, quality data, information about wait-times, our veterans' satisfaction, patient satisfaction. And you shared with us the Web site, accesstocare.va.gov.

Secretary SHULKIN. Thank you for that plug.

Mr. JENKINS. And you didn't ask for this, but I'll give it to you.

Secretary SHULKIN. Yes.

Mr. JENKINS. But I did look after you made mention of this and as I understand it from our discussion, this data has been out there. It has been available, but nobody was willing to authorize that the switch get flipped to make this available, and you did that.

Secretary SHULKIN. Yes.

Mr. JENKINS. So thank you for doing that and I encourage people to take a look. Transparency is good.

ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION

I want to make mention of this most recent executive order relating to some of the whistleblower and the accountability efforts. I can't tell you the number of times, whether it be a VA employee or others, about frustration or concern. Maybe very briefly describe this executive order and what kind of reassurances to those on the ground, at the grass roots, feel as though their concerns, their voices are going to be heard about reforming the system and truly holding it accountable and holding people accountable for good—the need for good performance.

Secretary SHULKIN. Well I think it is—I think that it is very important that people understand that we are taking these issues extremely seriously. That any organization that has been in trouble has to look towards its own leadership. And so we want to make sure that the people who are serving in our leadership positions are consistent and fulfilling the values that we owe our veterans.

And so when we become aware of issues of poor performance or people that have strayed from those values, we are taking action. And I think you can see that there has been a large number of those actions taken recently. Because of that, the executive order has asked us to establish an accountability office that will report directly to me as the Secretary.

As part of that, we are putting our whistleblower office in that accountability office to make sure that our employees know that if they raise issues to us, and if they are legitimate issues, that those employees will be protected. We do not tolerate retaliation and that is the way we learn and get better as an organization by addressing issues that are brought to our attention.

So these two concepts of adhering to our values and protecting our employees that raise issues are absolutely essential to our success.

PROVIDER PAYMENTS

Mr. JENKINS. One area I would like you to have staff look into, we get a number of calls to our office relating to the payment processes of the VA. You have described an effort to work collabo-

ratively with academic health centers, local hospitals that have real connections to the VA, make one plus one equal three, working together.

One of the challenges that I have heard, really starting with the restructuring of the payment system of the VA, from June of 2015 and it continues today.

I have got an academic medical center that really values and appreciates their good working relationship. The problem is the VA doesn't pay in a timely fashion. They have got literally hundreds of thousands of dollars in accounts receivable, from their standpoint—over 120 days. I have got a local hospital with over $10 million in accounts receivable from the VA over 120 days past due.

So, I am not sure what is going on in the accounts payment and claims processing, but I think we have got some real timeliness issue. And I hope that that will be taken seriously.

Secretary SHULKIN. Yes, you have to understand that this is the world I came from. And I do believe, if you deliver a service, that you deserve to be paid and you deserve to be paid timely. It is too hard operating those health care organizations and not get paid for the work that you are doing.

So I absolutely believe we have to get better at that. And I am not being defensive about this. We are not doing a good enough job in that area.

The way that I would suggest that we proceed is, when you find a community hospital that thinks that they have $10 million that we owe, please let us know, because, when we have dug into these, we absolutely owe them money. But it is usually not the $10 million.

There are duplicate claims in there. There are rejected claims in there that—sometimes they are looking at charges instead of the fee schedule that we pay them.

But we can work through that. We can put a team on that and get them the money that they deserve, and get it to them quickly.

Mr. JENKINS. Thank you.

Thank you, Mr. Chairman.

Mr. DENT. Okay. Mr. Taylor.

Mr. TAYLOR. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here today.

And look, I—we understand that there is nothing little about the big challenges that you face in your current position, so appreciate you for that.

I just have a—and I come from an area that has Hampton VA, which is the fastest growing—you know, OIF, OEF, women's veteran population is there. Personally, I am in the VA system myself, as well, so this is something that I am very passionate about, and I am looking forward to working with you to figure out some of these challenges and fix them.

CORRESPONDENCE POLICY

Quick question for you: if—one of us submits a question for your office, what is the—what is your policy in terms of the response? How many days?

Secretary SHULKIN. Yes, we categorize them into two types of responses. There are some that need urgent responses, and I think

that we are shooting for that for—I know I am going to get this wrong, because we just shortened the timeframe to become more responsive—14 days was our short one. And then—is it 30 days for our longer one? So he says I got it right.

So if there is something really urgent, we are going to do it in 14 days; otherwise, 30 days. And I know that that has not been the past experience from VA to your offices. This is our new commitment to respond to you in a more reasonable timely way.

Mr. TAYLOR. Thank you.

SUICIDE PREVENTION TRAINING

Let me touch on the—I have a bunch of questions, but let me touch on some of the most urgent ones.

Suicide is obviously something that has just been talked about, something that is also dear. I have a friend that has, you know, committed suicide. We have these issues, of course, in our area.

One of the things that I did submit to your office and haven't received yet is questioning your—the uniform policy, because I understand that the VA, according to the I.G., of course, is—has sort of decentralized, if you will. Is there a uniform policy, currently, with people who are trained to intake folks who come up, physically, that either, you know, exhibit signs of suicide or say that they are—suicide?

And furthermore, is there a uniform policy for the crisis hotline, which, I understand, is also being manned by call centers? What is the uniform policy there? And what is the training that those folks at the call centers get?

Secretary SHULKIN. Yes, I have seen some communication. So are you saying we are over 30 days already?

Mr. TAYLOR. Yes, Mr. Secretary.

Secretary SHULKIN. Okay, well, this is how I learn, so thank you. My guess is you will be getting a response pretty soon.

Mr. TAYLOR. Appreciate it.

Secretary SHULKIN. But I am aware of the issue—that there was concern about a lack of consistency of training between suicide prevention coordinators that live in our medical centers and Veterans Crisis Line responders who respond either from Atlanta or upstate New York.

They are different professionals. Our Veterans Crisis Line responders are licensed mental health professionals. They receive much more clinically intensive training. Our suicide prevention coordinators don't have to be that. They are doing different functions. Many of them came out of different disciplines.

And so there are different trainings. But among those two categories, there should be consistency among Veterans Crisis Line responders and suicide prevention coordinators.

So we will take a look for your correspondence to make sure we get you back the response very soon.

Mr. TAYLOR. I appreciate that, Mr. Secretary.

Also, just one other thing on suicide. Is there any openness to a potential public-private type things with qualified nonprofits?

So, for example, when I—when I say that, I—you know, there are a lot of veterans of course who are not comfortable with going to the VA or not comfortable with walking up or calling, but may

need help, but may feel more comfortable with some of the nonprofits out there that—they themselves typically are manned by a lot of veterans as well, too, have gotten out and seen this problem firsthand.

Is there any openness to a sort of pilot program potentially for public-privates to help with that?

Secretary SHULKIN. Well, not only an openness. We think it is absolutely essential. There is no other way to do this. Of the 20 veterans a day that are taking their life by suicide, 14 of them do not get their care in the VA system. So they are out in the community. Six are within the VA system.

So if we don't reach out and do the types of partnerships that you are talking about, and getting everybody involved, there is no way we can adequately address this. So we have been outreaching. We are working with Give an Hour, working with the Cohen Veterans Network, we are working with a lot of our VSOs on this. We have public service announcements.

If you have groups—there is a new group I just reached out to called Headstrong, the Galleon Organization. So, if you have new partnerships you would like us to explore, we are absolutely open to those.

Mr. TAYLOR. Thank you, Mr. Secretary.

Can you—I will have follow up, like I said, in the next round. But, just really quick, you have mentioned earlier that some of the under—underutilized buildings—I think there are 735—and then how many were vacant, you said?

Secretary SHULKIN. 435.

Mr. TAYLOR. 435. I will hit you on the next round. Thank you, Mr. Secretary.

Mr. DENT. Thank you.

At this time, I would like to recognize the gentleman from Ohio, Mr. Ryan, for 5 minutes.

Mr. RYAN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. Good to see you again.

PATIENT-CENTERED CARE

Appreciate our meeting yesterday. Let me just say publicly, I think what you are doing in your patient-centered care area with Tracy Gaudet is some of the most exciting stuff going on, not just in the VA, but in government today, of really figuring out quality solutions, integrating care, all the rest.

I just want to say thank you for throwing your weight——

Secretary SHULKIN. Thank you.

Mr. RYAN [continuing]. Behind that. I think it is really, really important, and I think we are going to start seeing a lot of savings because of that, and healing a lot of vets. So I want to say thank you right out of the gate.

VETERANS CHOICE PROGRAM

In our conversations that we have had already, I appreciate the balance that you are trying to strike between the VA clinics and the Choice Program. And I know that is not always easy.

One problem area that we have become aware of in my office is that, despite the Choice Program being authorized and appro-

priated, we still have veterans traveling significant distances to try to get their care. And if a veteran has a clinic within 40 miles, but the clinic doesn't offer the services they need, the veteran is being told they are ineligible for the Choice Program and being referred to the nearest VA clinic with the services offered.

There appears to be no policy that places a cap on the distance the veteran would have to travel if they fall into this loophole.

And in my district, which includes veterans in Warren, Ohio, traveling 3 to 4 hours to a round-trip weekly, sometimes more than once a week, to receive treatment in Cleveland. And I was at my son's little soccer practice and I had a couple of vets at the same time grab me about this issue.

The primary care physician or primary coordinator of benefits has independent authority to assign a veteran to travel an extreme distance with no limit established by the VA. Or they can refer them in the community of care to a local doctor, or they can elect to refer them to Choice. However, it requires a justification that there is an excessive burden on the veteran.

And you mentioned in your testimony establishing a priority on transparency. However, I can't find, and my staff can't find, a readily issued pamphlet, flyer or billboard which would explain to our veterans what defines a burden that would make them eligible for Choice in this particular situation.

I have cosponsored legislation with Representative Stefanik and Dr. Ruiz to correct this issue. So my question to you is: Do you have the authorities you would need to fix the problem? And what can we do quickly, instantly to provide more transparency and enroll our vets in the decisions for their care? And if we can't fix it immediately, is there a legislative issue that we need to deal with?

And I guess lastly, and more comprehensively, will the Choice 2.0 consolidation with Community Care correct this problem?

Secretary SHULKIN. Yes, well, lots of important questions that you have in that.

So in designing a health care system, I would not necessarily have picked mileage and wait-time as my criteria for how to design the system. I understand why Congress did, and you know frankly, to put a National program up so quickly, I think it was a very well thought-out effort that Congress had.

But now that we have had time to experience this, I believe a health care system should have a clinical basis to the way it is designed. So it is my intent in working with you to present an alternative to 40 miles and 30 days; in other words, to eliminate that and to replace it with something that makes sense from a veteran's clinical needs.

So, to look at access and clinical quality as the alternative to geography and wait-time. Under the current system that we have, which is still having to follow the rules that were set by Congress, 40 miles and 30 days, we do, as you correctly said, have the ability to define excessive burden. What we found, quite frankly, right after I became secretary, was that we had put out five, sort of, bullet points about examples of excessive burden.

The field had interpreted that as those were the only exceptions they could use. We have now clarified that. What we are trying to

do is to get the veteran and their doctor, or their provider, to have an interaction about what excessive burden is.

And we have now loosened up the requirements so that the field can make reasonable judgments about excessive burden. Because some of the examples, like the ones you are giving, really aren't acceptable.

Mr. RYAN. Right.

Thank you, Mr. Chairman.

Mr. DENT. At this time, I would like to recognize the gentleman from Nebraska for 5 minutes, Mr. Fortenberry, vice chairman of the subcommittee.

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Secretary, welcome.

Secretary SHULKIN. Thank you.

Mr. FORTENBERRY. Are you enjoying the new job?

Secretary SHULKIN. Yes, thank you.

Mr. FORTENBERRY. Well, apparently you are and I am grateful for your projection of an attitude of entrepreneurship and innovation, as well as compassion for this essential mission. So thank you very much.

Secretary SHULKIN. Thank you. I appreciate that.

PUBLIC-PRIVATE PARTNERSHIPS

Mr. FORTENBERRY. In your opening statement, you also referenced the new idea that has emerged that has now been empowered by legislation, of a unique public-private partnership that is going to happen in Omaha. I want to unpack that a little bit more for the committee, just so that everyone understands how potentially transformative this could be.

The community wanted to go on the point—community leadership came to congressional leadership and said, you know, we have built housing for veterans; we have built housing for troops. Could we possibly participate, through some charitable entity in updating and upgrading the hospital there which is in serious need of not only a facelift, but serious innovation—modernization.

So working with my predecessor, Congressman Brad Ashford, we got the empowering legislation to you. The community has committed about $30 million to build upon the money that had been set aside for a new hospital, about over $50 million. And we are going to move forward.

I think it is exactly the model of what you are talking about in terms of creating the 21st century architecture for a modern VA that is looking to community resources when available to go, not just into looking for charitable funds for donation purposes, but an integrated service environment as you referenced earlier.

This new facility will be an add-on to the existing hospital, ambulatory care facility; be proximate to Creighton Med School, as well as the University of Nebraska Med School who you already work with.

So the synergies of their design will become a bit seamless, or as we say, non—the veteran won't know the distinction between the type of care that they are getting. They are just getting the best possible care under VA auspices using private sector re-

sources, charitable monies that have gone into the clinic, because that is the objective.

So, I wanted to spend a little time just unpacking that further, and hopefully, given the very difficult, sad experiences we have had with watching burgeoning cost overruns, the Denver hospital being the poster child, that this way of proceeding forward is undoubtedly going to tap into a large pool of good will that exists out there in the country among charitable organization and leadership in various communities, to want to assist you in modernizing, innovating and creating the types of partnerships that utilize the best of the private sector, but always under VA's auspices.

So I am excited by this, and I am sorry to spend so much time on it, if you want to comment on that.

I also want to mention 50 miles down the road in Lincoln, we have a traditional, beautiful campus for a VA clinic. A similar type of dynamic is occurring where a charitable foundation with the city has agreed to build out veterans' housing on the site of the old clinic.

We are awaiting the decision as to what is going to happen with the new clinic. So if you could give us some update on that process, that would be helpful. But again, once again, the synergies being created with existing facilities, preserving traditional, beautiful architecture in proximity to the city's own private sector medical resources, again is a new opening dynamic of what I hope is a new chapter of the VA.

RECREATIONAL THERAPY

Third point, right quick. I have become aware and a little bit involved with a charitable organization called Project Hero. Your under secretary, Dr. Poonam Alaigh, has given a memorandum of understanding to your VA directors that they can partner with this organization using recreational activity, bicycling primarily, to be integrated into VA's services.

Studies have—there are metrics on this already showing improved health care outcomes, lower costs, sense of well being, drops in suicides. The study comes out of Georgetown. Again, I just wanted to highlight that for you because I think this is one of those types of programs consistent with what I said earlier.

It has been developed because of compassion and initiative by the private sector, looking to partner with the VA. And we have got a great opportunity here.

PUBLIC-PRIVATE PARTNERSHIP

Secretary SHULKIN. Right. Well, thank you.

Just briefly on your three points. The project in Omaha, Nebraska is exactly what I think we are looking to do in the VA, which is do things differently. In this case, we are going to build a new facility. It is going to be good for veterans and absolutely good for taxpayers.

This is going to leverage the federal dollars in ways that in the past we wouldn't have been able to do before. And if it really wasn't for your leadership and support in getting this through legislatively and the whole way through, it wouldn't be happening. So I think this is a transformative model.

We have four other sites that you authorized after Omaha, Nebraska, that we can do. So I am hoping that other committee members are listening because we have a list of 20 sites that now are eligible for this. I think this should become the way that we build a future modern health care system, so thank you for your leadership again on that.

LINCOLN, NEBRASKA CLINIC

Secondly on Lincoln, absolutely we are moving forward with a new clinic there. It should be awarded this fall and through the whole build and design process, even though I pushed really hard, probably the opening gate is going to be in early 2020. So it takes a while to do this. But that is well underway and it is really towards the top of our list.

RECREATIONAL THERAPY

On your third point about Project Hero, you know, one of the great things about VA is—is that it defines health care much broader than just physical illness. It defines it as physical, psychological, social, economic, and an example of using sports and adaptive sports to help people get better and have a sense of well being is something that frankly VA taught me a lot about.

And this is a great example. And so we are very supportive of this and other work around the country like this, and thank you for bringing this to our attention.

Mr. DENT. Thank you, Mr. Fortenberry.

At this time, I will move into our second round of questioning and I will start.

CHOICE PROGRAM FUTURE FUNDING

Dr. Shulkin, in the one-page fiscal year 18 skinny budget we received in March, there is a VA request for $2.9 billion in new mandatory funding, presumably to complete the fiscal year 2018 funding for the Choice Program, after the mandatory $10 billion of the program is completely exhausted in January.

Does this indicate the administration's intent to fund the successor Choice Program with mandatory funding?

Secretary SHULKIN. Yes.

Mr. DENT. Okay. Next question.

Being an appropriator, I always try to keep my eye on the bottom line of new initiatives. I am aware of at least two proposals. While we certainly support them from a policy perspective, our budget antennas are on alert.

OTHER-THAN-HONORABLE DISCHARGES

You have announced that you intend to provide emergency health services to veterans who have other than honorable discharges. You have also testified in the Senate that you are interested in expanding caregivers—to veterans from before the post-9/11 era.

How do you plan to fit these added costs into your budget when you are obviously already struggling to cover expenses for your current VA patients?

Secretary SHULKIN. Chairman, maybe this doesn't fit into the budget but basically, I don't care. [Laughter.]

I sat in a session that was organized by members of Congress, members of the House, where there was a young man who sat right in the Capitol Rotunda who said that he had been deployed to Afghanistan six times. And on his return, he found out that his wife left him. And so he took off across the country to try to find her. He was declared AWOL and other than honorable.

You could see he was suffering from severe mental and emotional disorders. And he went to a VA and he shows up at a VA and says I am here because I need help, I am suicidal. And the VA says, I am sorry, you are not a veteran. Well, he had served our country six times—six tours. That is just not acceptable.

When we say that there are 20 veterans taking their life every day, we know it is this group that is among the highest. No one wants to help them. Well, I am not just going to sit by. So I don't want more money for this. We are going to find a way to help these people and then connect them in the community to resources and get them help because that is the right thing to do.

So I am going to find the way to do that because I think this is our——

Mr. DENT. That is a very compelling story and I am glad you are taking that initiative.

Secretary SHULKIN. And I am sorry, Chairman, what was the—what was your other question?

Mr. DENT. Caregivers.

CAREGIVERS PROGRAM

Secretary SHULKIN. Caregivers. Yes. So—so the Caregivers Program is really, really important. We were authorized to be able to do that for post-9/11 veterans and there have been tremendous successes. But we frankly didn't get this program right. We have been issuing in some areas up to 90 percent revocations of caregivers that we had authorized. Something is wrong there.

So we just issued a national suspension of revoking caregiver status and we are now in a pause where we are going to look at what are the right policies in order for veterans to get access to caregivers. It is our intent to be able to bring this to pre-9/11 caregivers because frankly, the most vulnerable group right now are elderly veterans.

And the worst situation is when somebody is in their home and they have to leave their home to go to an institution—a nursing home. Because, one, most veterans don't want that; most people don't want that. And secondly, it is the most expensive way to care for elderly people.

If we can keep them in their home with caregivers, we should be doing that. So we are looking at how do we use the current money and potentially come up with even better policy than what we have today. And we are going to be announcing that in probably the next couple months.

Mr. DENT. Thank you.

SCHEDULING SYSTEM

The VA's antiquated scheduling system has been a particular concern to you, I know. We understand you are on a dual-track to modernize it, piloting a commercial system MASS, as well as upgrading your existing system. I guess you call it VSE.

It seems like these efforts might lack a unified strategy. Why are you interested in investing in two systems simultaneously? And will the scheduling system be further tinkered with in the electronic record overhaul?

Secretary SHULKIN. Yes. On the surface, I agree with you. This makes no sense at all. Why would you invest in two different paths. We awarded a commercial off-the-shelf product called MASS. That is the system that we think meets our solutions and that is the one that we are implementing. We are working right now on a pilot site to be able to create the interfaces so that we can do that.

The rollout of that across a system as big as ours is going to take several years. In the meantime, we had developed an internal system, one of the, frankly, last I hope that we ever develop, but this one is developed already with taxpayer dollars. And we did an evaluation in the month of February. We have rolled it out to eight sites. It is actually working. It is much better than what we have right now.

So as an intermediate stop-gap measure, we are rolling it out across the country because it has already been developed, and it will help in that intermediate period of time until we can get a commercial off-the-shelf system up.

Mr. DENT. Thank you, Secretary Shulkin.

At this time, I would like to recognize the ranking member for 5 minutes in a second round.

MILITARY SEXUAL TRAUMA

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

I want to focus on military quality of life, because at that hearing that we had in March when we had an opportunity to meet with the senior commissioned officers, we discussed the Marines United scandal, which we discussed in my office yesterday.

Many of the victims of that really horrific social media site are now veterans. And I have met with a number of them, as have many of the women members. And I would like to know what the VA is doing to provide them with the necessary care and support they need, because these are women who have had, you know, without their permission nude photos of themselves posted. They have been subject to extreme humiliation.

With regard to the military sexual trauma system that the VA has, how have you let veterans know that this service is available and what outreach have you had?

Secretary SHULKIN. The VA has an extensive system for treating military sexual trauma. We actually have worked with the Department of Defense so that the VA is a place where people can go confidentially and get treatment. Women or men who have suffered military sexual trauma can come into any of our Vet Centers and

there will not be a connection of their medical record back to the Department of Defense.

Ms. WASSERMAN SCHULTZ. Mr. Secretary, and I appreciate that, but specifically what kinds of outreach are you doing to not only make sure that victims of sexual assault in the military are aware of those services, but also specifically the victims of the Marines United scandal?

Secretary SHULKIN. When we met in your office, you actually suggested that that is something we should be doing. I don't believe that we have done that. I agree with you it is something we should be doing. And so as a result of our conversation, we are putting together a plan for that specific outreach. So thank you for that suggestion.

Ms. WASSERMAN SCHULTZ. Okay. No, you are welcome. I mean, we have female veterans that are committing suicide at a rate of six times that of women civilians. And, you know, identifying ways and implementing strategies to address the unique mental health needs of women is critically important. And so I would appreciate it if you and your staff would follow up with us on that.

Secretary SHULKIN. Yes.

[The information follows:]

VA is committed to assisting the individuals affected by the Marines United issue to the fullest extent possible.

Since becoming aware of this situation, staff in VA's national MST Support Team has reached out to colleagues in DoD Sexual Assault Prevention and Response Office, leadership in the Services' Sexual Assault Prevention and Response programs, and DoD Health Affairs to remind them of the availability of MST-related services through VA.

VA's current MST treatment authority (provided by § 1720D of Title 38, United States Code) requires that sexual assault and sexual harassment experiences occurred while a Veteran or Servicemember was on active duty, active duty for training, or inactive duty training. As such, VA has concerns that the authority may not cover care for all individuals affected by this issue—for example, those incidents of harassment occurring after an individual has left the military. VA will continue to explore what is possible to provide under its current authority, in order to extend support to as many affected individuals as possible.

SENATE-CONFIRMED POSITION VACANCIES

Ms. WASSERMAN SCHULTZ. The other question that I wanted to touch base on is what I mentioned in my opening remarks. And that is the—the openings—the really significant and serious openings that you have in all of your Senate-confirmed positions. And you mentioned that you were going to be making an adjustment in how you fill those positions.

But I am actually wondering, one, if there are any problems that the Administration is facing in identifying candidates for those positions. Are you having trouble filling them? And in particular, I find it extremely troubling that the Under Secretary of Health, the Assistant Secretary for Information and Technology, given the very serious problems we have talked about here today, and the Chairman of the Board of Veterans Appeals, are all positions that remain empty.

What is the timeline for filling those? And do you have candidates that you are considering? And are you having trouble filling them?

Secretary SHULKIN. Well, I appreciate your concern about that. I am very impatient, and of course, I want my team in place. We have obviously very good career, acting professionals that are handling these right now, but I want permanent people in place. The Under Secretary for Health and the Under Secretary for Benefits—I am not sure if you are aware—it is mandated that we form commissions to actually search for those positions.

The Under Secretary for Benefits Commission met approximately 10 days ago to go through candidates and are recommending several of them for me to see, and then me to recommend to the President. And the Under Secretary for Health Commission, I just saw the committee members appointed this morning. That will be going forward in the next probably two weeks as well.

For CIO, I have met a number of candidates. We are vetting them right now, trying to move forward with an offer. And at the Board of Veteran Appeals, we are also trying to vet a candidate also.

So, I hope that, you know, these processes, having gone through it myself, my own vetting process, 13 months, it takes too long. And we are looking to move through this as soon as we possibly can.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

I will have one in the third round. So I appreciate it. Yield back.

Mr. DENT. Thank you.

At this time, I would like to recognize the gentleman from Florida, Mr. Rooney, for 5 minutes.

Mr. ROONEY. Thank you.

CHOICE PROVIDER PAYMENTS

And Mr. Secretary, I just want to say that your office I guess is watching this hearing and has already gotten with my office regarding some of the issues that we are discussing with our constituents. And I want to give a shout-out to Mary Kay in Lake City. And if you are still watching, Mary Kay, I have another issue for you to work on.

That is with regard to—a lot of my district is very rural. And, you know, I do have some of the coast, but a lot of the people that live in the district live in the countryside. And one of the issues they complain was with the Choice Program is that that is long wait-times. They are receiving complaints about long wait-times for VA appointments, referrals, payments through the Choice Program.

And the payment and reimbursement process to the providers is difficult, probably exacerbated because it is rural. So we, you know, obviously, in that situation, you have smaller hospitals and clinics. And many of the providers that are technically participating in the Choice Program are refusing to accept Choice patients because they know that they will have to wait a long time to get paid themselves.

So some providers that don't accept the Choice patients will only do so if the veteran agrees to pay for the services up front, and that leaves the veterans in that same bind they were in before Choice, which was either face the excessive wait-times at the VA facility with no option to obtain immediate care elsewhere without paying

out of pocket first. And obviously, that is not the point, or that is not what we are looking to do.

So, I mean, you as a doctor can probably appreciate, you know, what these people that want to take the Choice Program to help veterans, but they know that it is going to take forever to get reimbursed. It would be like, "hey, will you pay me first, and then, you know, we will deal with getting reimbursed later." I don't know if that is the rationale, but it sounds like that.

The OIG has criticized the VA's monitoring oversight for these contracts and reported that these contracts still don't have performance measures to ensure the contractors pay their providers in a timely manner. And the OIG made this recommendation January 30th of this year.

So as you work to expand the Choice Program, how are you implementing the OIG's recommendations specifically with regard to timely reimbursements?

Secretary SHULKIN. Well, there is no doubt that this is an area of significant risk for us; that monitoring and making sure that the providers are paid is critical because of the issues that you are saying. The veterans are being put in the middle. I would not recommend that veterans put out money for this. That, as you said, is not the point of it.

What we have done is we have done multiple contract modifications. We have actually advanced money to the third-party administrators. I have suspended the requirement that providers have to provide their medical records to us in order to get paid.

We are improving our payment cycles through the Choice program, but it is not perfect by any means. We have to get better at our auditing of these processes. And those were the I.G. recommendations, and we are working on doing that. So this is a significant area of risk for us.

In the reauthorization, or the redesign, of the Choice program, what we are calling Choice 2.0, we want to eliminate the complexity of this process. The private sector does not have to do the type of adjudication of claims that we do. They do auto-adjudication. They do electronic claims payments.

We just are not able to, under this legislation, do all the things that, frankly, we know are best practices. That is what we want to get right in Choice 2.0.

Mr. DENT. Thank you.

At this time, I would like to recognize the gentleman from Ohio, Mr. Ryan, for 5 minutes.

Mr. RYAN. Thank you, Mr. Chairman. It is nice of all you Pennsylvania guys to let an Ohio guy participate in this hearing. I appreciate that.

Mr. DENT. We beat Ohio State last year, that is why.

Mr. RYAN. Blind squirrel finds a nut every now and again, Mr. Chairman. [Laughter.]

CHOICE AND COMPLEMENTARY MEDICINE

Mr. Secretary, a couple of quick questions, one with regard to the Choice Program again.

There are a lot of people who want to—and we have seen it—I have seen it in the last few years at the D.C. VA and other VAs,

where you have Centers of Excellence, where there are all these complementary services that are being provided that are having—showing significant success in reducing pain, managing pain, reducing opiates, which is a huge thing for us to be able to do, providing these alternative approaches.

And I just want to make sure, as we are moving to try to better administer the Choice Program, that these evidence-based programs are covered in the Choice program so that they can access, whether it is acupuncture or mindfulness-based stress reduction. I have seen programs like Project Welcome Home Troops, where they do a lot of breathing exercises with these veterans that are having transformative effects with their post-traumatic stress. Transcendental meditation is another one that they use.

There are a lot of videos online you can watch where these vets that are on 10 or 12 prescription drugs, after going through some of these therapies that aren't traditional, I guess you would say, going down to two or three meds, which is a huge savings for us.

And you are actually giving these vets the tools they need to be able to go out into the world and function and get a job and be productive members of our society. So I want to make sure, as we move with the Choice Program, that these—again, evidence-based programs are covered by the Choice Program.

Secretary SHULKIN. Yes. Those types of services and providers are part of the Choice Program. We are expanding the network so that we have more access to those types of providers.

Mr. RYAN. Great. I think that is going to be a big thing, not just for the vets, but out in society as well.

APPEALS MODERNIZATION

The other issue is we are talking about dealing with the appeals process. And we had this conversation, again, yesterday. But the legislation currently is not going to affect the hundreds of thousands, almost 500,000 people who are already caught up in the stagnant appeals process.

So I say this not to you, because I have already said it to you, but to members of the committee and to the public. I think it is important for us to figure out how we can help you start to reduce this backlog. How do we get more appeals judges, maybe out of retirement, to get into this program?

Congressman Womack and I are already working on some legislation to be able to do that. And so, if your department can provide us with the necessary metrics that we would need to figure out how many, you know, retired appeals judges from the Board of Appeals do we need to get back in the system, even on a part-time basis, to start getting through this backlog, and so if you could make sure——

Secretary SHULKIN. Yep. Yep.

Mr. RYAN [continuing]. You get us that information.

Secretary SHULKIN. I appreciate that suggestion. At 470,000 backlog claims right now, so even after legislation was passed and we fix the process going forward, we still have that backlog.

I appreciate your offer to work with us and see if there is a way to help with that. And we have already worked up some numbers we would be glad to share with you.

[The information follows:]

Modernizing the appeals process is a top priority for the Department of Veterans Affairs (VA or the Department). The current VA appeals process, which is set in law, is broken and is providing Veterans a frustrating experience. In the current process, appeals have no defined endpoint and require VA staff to engage in a continual loop of gathering evidence and readjudicating that information based on that new evidence. This continuous process of gathering evidence and readjudication can add years to the appeals process, as appeals churn between the Board of Veterans' Appeals (Board) and the agency of original jurisdiction (AOJ). All of this has resulted in a system that is complex, inefficient, ineffective, and confusing. Additionally, it splits jurisdiction over appeals processing between the Board and the AOJ, which is typically the Veterans Benefits Administration (VBA). Due to this complex and inefficient process, Veterans wait much too long for final resolution of their appeal. In fiscal year (FY) 2016 Veterans waited, on average, 3 years for resolution on their appeal. For those appeals that were decided by the Board in FY 2016, on average, Veterans waited at least 6 years from filing of their NOD until the Board decision issued that year. Without significant legislative reform to modernize the appeals process, VA projects that wait times and the cost to taxpayers will only increase.

Comprehensive legislative reform is needed to provide a modernized system going forward that will provide Veterans a decision on their appeal that is timely, transparent, and fair. Additionally, VA must address the pending legacy appeals inventory. As of April 30, 2017, there were 470,546 appeals pending in the Department. Of those appeals, 323,851 were with the AOJ and 146,695 were with the Board. VA projects that, without legislative reform, the pending appeals inventory will continue to increase far beyond VA's processing capacity. Additionally, VA continues to assess the current and future allocation of full-time equivalent employees to work appeals to ensure that the pending legacy appeals inventory is addressed in a timely and efficient manner. Whether VA will need additional resources for appeals after enactment of appeals reform legislation is contingent upon resource allocation decisions made by the Department and the Administration during the annual budget process and cannot be predicted at this time.

Regarding the number of judges needed, in February 2017, the Board brought on a large group of 26 new Veterans Law Judges (VLJ). The Board does not, presently, anticipate a requirement for additional VLJs for the remainder of this fiscal year or next fiscal year. The Board evaluates its VLJ need based on the resource level and its ratio of attorneys to VLJs. The Board aims for a ratio of nine attorneys to each VLJ. While the Board appreciates the interest in the number of VLJs needed to address the pending appeals inventory, the greater resource need is for additional attorney staff. VLJs review and sign draft decisions prepared by the Board's attorney staff in the Office of Veterans Law Judges (OVLJ).

During the May 3, 2017 hearing, the topic of getting more appeals judges, out of retirement, was discussed. While additional VLJs may be required in the future, the Board's greater need is generally for attorneys to prepare draft decisions for review by a VLJ. VA is open to any potential future solution that would generate more draft decisions for VLJ review and signature, to include hiring reemployed annuitants. The Board has employed reemployed annuitants to a limited degree in the past; however, we view this approach as one of only a number of ways to bring additional attorneys on board.

It is worth noting that VLJs can only be efficient in reviewing and signing draft decisions if the quality of the drafted decisions reflects specialized experience in Veterans law. It typically takes 6 months to 1 year to fully train Board attorneys to draft decisions, and that is not just for new attorneys. The Board has, over the years, hired a number of experienced lawyers, including former military JAG attorneys, lawyers with experience in Social Security disability law and with other similar backgrounds, and the learning curve in the area of Veterans benefits law is about the same.

Mr. RYAN. Great.

Secretary SHULKIN. Congressman Womack.

Mr. RYAN. Great.

Mr. Chairman, I think that is an important step for us, to try to dig into this 470,000 number. Is with the appeals that, some of them, are 30 years in the making. And for every additional piece of evidence or paperwork that they add, it just slows up the process.

And we—I think we have got to make a concerted effort. Congressman Womack—I won't steal his term, but—was talking about a surge for judges to help dig through this.

So thank you, again, Mr. Secretary, for all your leadership. We appreciate it.

Thank you, Mr. Chairman.

Secretary SHULKIN. Thank you.

Mr. DENT. Mr. Taylor from Virginia is recognized for 5 minutes.

FRAUD, WASTE, AND ABUSE

Mr. TAYLOR. Now I know that you are looking for efficiencies, and waste, fraud and abuse, and all those things. And I would like to just briefly touch on that.

And I—but I—first, I want to applaud you for taking the stand and helping veterans that may have been dishonorably discharged, and some of that, because of effects and stresses that they had on their own personal lives and everything from war, quite frankly.

That being said, even in our own VA, when we walk through it, and we we noticed and asked questions, and certainly saw that there were folks that were being treated there that may not be eligible via the system currently. So in a couple areas of Hampton, and it is in my letter to your office, as well, too—or e-mail, I think it is.

It talks about how there are a couple of areas there where we—you have these veterans that are honorable, veterans—no issue. But, you know, when they need a knee replacement or something like that that is not service-connected, that they are not eligible for, that they may be getting treatment there in the VA.

That is a huge cost, with zero reimbursements, potentially, from Medicare, Medicaid or their private insurer, whatever that might be. So one of the things that we sent in there—and I don't know if you—there is an active study for it now—is, if you exacerbate that across the whole VA system, that is significant dollars.

And veterans, either knowingly or not knowingly, because this is not a politically popular thing to say—but I am a veteran and I don't care—if you know you are not supposed to be treated there, then you don't get treated there, because you are taking away from other veterans that should be treated.

That being said, we want to take care of people as much as possible. But I am fearful that, in the political climate, that maybe the VA is seeing folks that aren't supposed to be there, that should be using their own private insurer, or whatever they are on, insurance-wise.

So have there been any studies that are looking into that to figure out what is it that is costing the VA across the whole system?

Secretary SHULKIN. Yes. We absolutely have looked at this.

As you know, there are—veterans are classified into eight priority groups. The first three, generally, are service connected. The next three, so four through six, are generally income related, low income. So, when you start getting to seven and eights, those are people that fall outside of that, and currently that is frozen.

So not all veterans, as you are saying, are eligible for care in the VA system and so we are focusing on those that are service connected and lower income. So—and I think that is a——

Mr. TAYLOR. If I may?

Secretary SHULKIN. Yes.

Mr. TAYLOR. Has there been any review, if you will, where that may not be the case? I know that we are focused on the folks that are supposed to be in the system—that is supposed—that need care and everything like that. But has there been a review across the whole spectrum to figure out, in fact, if they are—I am not trying to say it is fraud necessarily, maybe, but in some instances it may not be. They just may not know otherwise. But have we had a report across the system to figure out those inefficiencies and what those costs are for the VA.?

Secretary SHULKIN. Yes. We know exactly how many people are in each of these priority groups.

Mr. TAYLOR. Not the priority groups. I am sorry. I didn't mean to interrupt.

Secretary SHULKIN. Yes.

Mr. TAYLOR. Not the priority groups, but I mean folks that aren't supposed to be getting care that are getting treated.

Secretary SHULKIN. Well, I am not aware of any veterans that are getting care there that shouldn't be. If they are, then we have to address that and stop that, because we do check, except in emergency care, you know, eligibility criteria when people come in. And if they are not eligible for care, we generally are telling them that.

Now, you know, maybe you are aware of some situations and I would really like to understand that better, because I think you are correct in your assumption that our care needs to be focused on those that are eligible for care, particularly when we have access issues. So I would be glad to talk to you more about that.

[The information follows:]

HAMPTON VA MEDICAL CENTER (HAMVAMC)

VSSC Enrollment and User Data, FY2016 Non-Veteran/Humanitarian Patients = 1,095

Urgent/Emergency Care: HAMVAMC is compliant with the Emergency Medical Treatment and Labor Act (EMTALA) and accompanying federal regulations. EMTALA requires hospitals with dedicated emergency departments (ED) to provide a medical screening examination to any individual who comes to the ED and requests such an examination, and prohibits hospitals with EDs from refusing to examine or treat individuals with an emergency medical condition. HAMVAMC ED will provide necessary stabilizing treatment for emergency medical conditions within the hospital's capability and capacity. Stabilized patients who require additional care and are not eligible for Veterans Health (VHA) enrollment are appropriately transferred to a community-based hospital/provider.

Some patients who are pending VHA enrollment determination may continue to receive VHA care until eligibility is adjudicated by the VHA/Health Eligibility Center (HEC). If a patient is later determined to be ineligible for VHA enrollment, VHA/HEC grants the patient a 60-day waiver period in order for the patient to provide additional evidence or documentation to support eligible-Veteran status. After 60-days and no supporting evidence, the patient will be appropriately and safely transitioned from VHA care to the community.

I do want to just mention two things. First of all, our policy is for emergency mental health care for other than honorable, not dishonorably discharged. Dishonorably discharged we are not——

Mr. TAYLOR. Sorry if I misspoke.

Secretary SHULKIN. Yes. Yes. Okay.

Mr. TAYLOR. But I do applaud you for—I know that there are a lot of wounds that are mental of course and——

Secretary SHULKIN. Absolutely.

Mr. TAYLOR. And I get that. I applaud you for those efforts.

Secretary SHULKIN. And the other thing I just want to mention is that your letter of March 29th, we did respond by April 6th. We actually made it in 14 days. There is additional information that your office wants on the protocols on the Veterans Crisis Line so we are providing that to you and certainly want to get you that detail.

Mr. TAYLOR. Thank you. I appreciate it.

Mr. DENT. Thank you, Mr. Taylor.

At this time I guess we will move into a third round of questioning for those who remain. So with that, I thought I would just quickly touch on a couple of issues.

OPIOID ABUSE PREVENTION

First, Mr. Secretary, as you know we included $50 million in the omnibus appropriations bill that is going to be considered on the floor, I guess right now, for VA opioid abuse prevention and treatment efforts. We realize that the VA has really come a long way in opioid management efforts since the horror stories at Tomah, Wisconsin and the Candy Land doctor situation.

What are the most effective approaches the VA has identified to keep severely injured veterans away from opioid dependency? And how are you channeling your funding to achieve those goals?

Secretary SHULKIN. Yes. Well first of all, thank you for that additional support. I can tell you it is money well spent. We have seen a 32 percent reduction of opioid use in the VA since 2010, but we have a lot more work to do. So this is really a good investment.

I would say, very briefly, that the VA approach to this, and we are leading American medicine in this—I just published an article on this—is a multifaceted approach. One is veterans need to sign an informed consent when they go on opioids.

Secondly, we actually monitor the profile of doctors so they can compare themselves to how other doctors are prescribing.

Third, we mandate participation in the State prescription data monitoring programs.

Fourth, we do academic detailing where experts go out and actually educate our clinicians on this.

And fifth, we are suggesting strong alternatives to opioids and providing those like complementary or integrated medicine in our facilities.

DISABILITY CLAIMS BACKLOG

Mr. DENT. I would also like to ask you, too, on—this relates to disability claims backlog management issue. We were pleased to learn last year that the VA had reached an effective zero on the size of the disability claims backlog. And I know some claims are

always going to exceed the target deadline because the VA is waiting for the veteran to produce some additional information. But you have brought that number down, I guess, from its peak of 611,200 in 2013.

But we understand that the backlog is creeping back up because of your shift in workload priority from initial claims to appeal cases. We know that the burgeoning appeals caseload needs to be tackled, but this highlights the management dilemma you face. And I think Congressman Ryan touched on that a bit.

What is your long-term plan to bring a balance between activity on initial claims and appeals workloads?

Secretary SHULKIN. Well, I don't think we are where we want to be on this. So we have to make continued progress. We are at 100,000 disability claims over 125 days and that needs to come down significantly. We are doing a number of changes to our processes. One is called decision-ready claims. That will allow a veteran to seek a much quicker resolution to their disability claims and give them a choice when they have all their information available to be able to do that.

We are still advancing our technologies, moving towards a paperless system. We have 10 sites now that are completely paperless. That moves everything through faster. We are looking at a number of other alternatives to do that.

So we do have plans to get this down and we are not seeking additional funds to do that. We see it through process improvements.

Mr. DENT. Thank you.

OFFICE OF AMERICAN INNOVATION

And finally, Jared Kushner's White House Office of American Innovation has apparently chosen the VA as its first target to reshape federal bureaucracy by making it leaner and more effective. Has his office fanned out staff at the VA to analyze its operations and make suggestions at this point?

Secretary SHULKIN. Yes. We are in close contact with Mr. Kushner's office. They have been extraordinarily generous with their time. And what they have really been doing is trying to bring industry partners and industry best practices in to help the VA. So I don't think that they are staffed to come in and do their own assessments, nor do I think that is their intent. It is more to identify solutions that already exist in the private sector and bring them in and modernize our system.

Mr. DENT. Well, thank you for sharing that.

AGENCY REFORM PLANS

All federal agencies have received an executive order to reorganize their departments by September, in line with their fiscal year 2018 budget cost-cutting proposals. Your acting deputy has said that the VA would like to get started sooner than that.

What changes do you expect in the way VA is organized and how it operates before the end of the year?

Secretary SHULKIN. Well, we are underway with this right now. I think, although I don't know all the specific solutions, because we are still working on it. I think what you should expect is that we are looking to have a smaller central office function, more stream-

lined. We are looking to move towards more shared services rather than siloed services in each of our administrations.

And we are actually looking across federal agencies to see other things that maybe other agencies are doing better that they should be doing for us or vice versa, whether VA should be taking on some of the functions that other agencies are doing. We are working with other secretaries on that.

Mr. DENT. Thank you, Secretary. That completes my questioning.

And at this time, I will recognize the ranking member for 5 minutes.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

VETERANS CRISIS LINE

I wanted to just ask you about the Veterans Crisis Line, because when we went to the D.C. VA hospital, we had a rather confusing conversation with their personnel that made it evident that there were a number of serious issues with the decentralized nature of the Veterans Crisis Lines—there being a National hotline, as well as a hotline at each hospital.

And so the I.G.'s report that came out highlighted how significant the concerns are. And within days of the I.G.'s report, the VA said that the issue had been fixed.

Can you explain how fixed it is and what does that mean? And what you are doing to ensure that our veterans are absolutely able when they are in crisis because of the risk of suicide being so high, are able to get the services that they need.

Secretary SHULKIN. I apologize for the confusion. There is only one centralized Veterans Crisis Line. Each of the medical centers do not have decentralized crisis lines.

What the I.G. was referring to was the fact that when the VA responders on the Veterans Crisis Line receive more calls than they could handle, they went to backup centers that were located around the country. Those backup centers are certified SAMHSA backup centers, so they are trained responders as well, but they are not VA responders.

We did not think that was satisfactory. So several months ago, we went out—we hired over 200 new responders, had to get them trained. They came online in the early part of 2017. We opened up a second center in Atlanta, Georgia.

And now because of these new responders and the second center that is online, we are able to handle the calls that are coming in. We have less than a 1 percent backup center rollover rate at this point. That is why we came out and said that we fixed that problem.

We have many days where we have zero rollover calls. Probably in the last 2 months, we average, you know, less than 10 rollover calls on a given day. We are responding to over 2,000 calls a day to veterans in crisis. We typically will send out 60 to 65 emergency responses to save veterans' lives.

Ms. WASSERMAN SCHULTZ. When we were at the VA hospital here, they described a system that was one that was based with their personnel, and one that kicked to the National system when it was after hours.

Secretary SHULKIN. Well, every—every VA has a mental health service. We have same-day services available. So if a veteran calls and is in crisis, they will be seen that day or their issue will be dealt with that day. So that does happen.

Every one of our medical centers has a suicide prevention coordinator. Many of them more than one. That is there to deal specifically with the follow-up issues and to address people in crisis on that day. But there is only one National veteran crisis line, and that is run out of two locations in upstate New York and one in Atlanta.

Ms. WASSERMAN SCHULTZ. Do they all receive the same training?

Secretary SHULKIN. They all—well, as I was explaining to the congressman, the Veterans Crisis Line responders all receive the same training because they are licensed health care professionals. And the suicide prevention coordinators all receive the same training, but different training than the Veterans Crisis Line responders because they are not all credentialed or licensed mental health professionals.

OFFICE OF AMERICAN INNOVATION

Ms. WASSERMAN SCHULTZ. Okay. And then you mentioned the reorganization and Jared Kushner's office's goals. Are those goals aligned with yours? Are you waiting for Mr. Kushner's reorganization recommendations before you begin hiring?

Secretary SHULKIN. No, no. Again, the American Innovation Office is not intended to come in and do assessments and give recommendations. That is the executive order has asked the department to do that. So that is what we are doing. Mr. Kushner's office is helping us in identifying industry best practices and strategic partners that can help us advance these modernization goals.

DISABILITY CLAIMS AND APPEALS BACKLOG

Ms. WASSERMAN SCHULTZ. Okay. And then just as I run out of time, on the Board of Veterans Appeals and the backlog and the issue of the disability assessment backlogs as well, are you aware of online electronic technology that exists that previously had contracts with the VA that no longer do? And that could significantly address some of this backlog?

Secretary SHULKIN. No.

Ms. WASSERMAN SCHULTZ. Okay. I would like to follow up with your office so that you can be aware of this technology. And while I have no preference for any particular contractors, the timeline and story that I have heard about the process that they have gone through leaves me frustrated that we have a massive backlog and a potential avenue to help address it, but no way in for a contractor like them to actually be a part of it.

Secretary SHULKIN. No—thank you, I would like to hear about that.

Ms. WASSERMAN SCHULTZ. Thank you.

I yield back.

Mr. DENT. At this time, I would like to recognize the gentleman from Virginia, Mr. Taylor.

Mr. TAYLOR. Thank you, Mr. Chairman.

I just wanted to say before I give my question, you are correct. We had the letter. I have it right here, so maybe I misspoke in terms of, you know, getting the answers. You know, yes, you responded. So the office responded.

Secretary SHULKIN. Right. I am just glad we responded.

Mr. TAYLOR. Sure. Thanks. I look forward to working with you on this.

FUTURE DEMAND ON VA

Continuing with the budget and, like I said, I understand that you are looking for efficiencies. And you mentioned earlier about 32 percent of the care being outside the walls of the VA, which is a 62 percent increase in 2 years. Right?

So, what is your office doing in terms of looking at inside and figuring out, yes, if we are looking at, and you are asking for the monies for Choice and to fully fund that in the mandatory—in the budget, that trajectory is pretty high. Right?

So what are we looking internally in terms of reducing the budget internally, if the care is being seen there? Are you just seeing complete demand exploding?

Secretary SHULKIN. Yes. I think the reason why we got into the crisis in 2014 is because we were not being honest about what the real demand is. And once we opened up both internal access and community access, we started to see what the real demand is.

So I think that we are reaching I believe—hope to be reaching a steady state where we are not going to see continued growth in the way that we have in the past, but that we are meeting the health care needs of our veterans and honoring our commitment.

Mr. TAYLOR. Okay. Thank you.

VACANT AND UNDER UTILIZED BUILDINGS

And the—back to the 735 under-utilized—do you have a rough idea what the cost is that you guys are spending that you don't need two per year on that.

Secretary SHULKIN. Yes, and in fact I have a chart that I gave to each of you, showing you where these are.

But the cost of the 435 buildings right now that are vacant is $6.7 million a year. Our total cost is approximately $25 million a year for all these buildings.

SUICIDE PREVENTION TRAINING

Mr. TAYLOR. All right, thank you. And then, jumping back—and I appreciate that, thank you. Jumping back to the suicide—and you mentioned the two different folks that are trained——

Secretary SHULKIN. Yes.

Mr. TAYLOR [continuing]. On suicide. So it is my understanding that—like Hampton, for example—Hampton VA, there is a call center that mans the suicide prevention hotline—or the suicide hotline, is that correct?

Secretary SHULKIN. No. No, the suicide hotline is a National hotline. The—you know, during business hours, the Hampton VA would be there to assist veterans in crisis.

The National hotline is run out of our upstate New York office. And now, in Atlanta, they have a second office.

Mr. TAYLOR. So I was in a contractor's office as well, too. And they said that they were the call center for the Hampton VA.

Secretary SHULKIN. Well, I am sorry. The—the VAs or—and, in some cases, the VISNs run a call center. They do not run the crisis line.

They run regular calls that come in and want to be, you know, ask for appointments or get to certain places through a telephone operator. We do run call centers across the country.

But they are—it is not—we only have one 800 number for our Veterans Crisis Line, and that is run out of upstate New York and in Atlanta.

Mr. TAYLOR. So that—the Veterans—I am just trying to understand.

Secretary SHULKIN. Yes.

Mr. TAYLOR. So the Veterans Crisis Line—and then—but if I call the Hampton number, say I am suicidal—

Secretary SHULKIN. Right. It will say, "dial 7". Right, the Hampton VA call center, what it will say is, "welcome," and, "if you are having issues related to suicidal ideation"—they use better words than that—"please dial 7. You will automatically be connected to our National Veterans Crisis Line."

Mr. TAYLOR. Okay, thank you.

And I have no further questions. I look forward to working with you. Thanks for your time.

Secretary SHULKIN. Thanks.

Ms. WASSERMAN SCHULTZ. Mr. Chairman.

Mr. DENT. Sure.

Ms. WASSERMAN SCHULTZ. I thank you. Just I really think that, if we are having a hard time understanding how the Veterans Crisis Line works, then imagine how veterans must feel. I don't think it is clear how it works and what happens from beginning to end, every hour of every day.

I think—I am glad that you have an additional, you know, service center that has your employees staffing it. But I don't understand the difference between who handles suicide—suicide calls on the Veterans Crisis Line and other mental health calls. I don't understand how it works when you are outside of business hours.

I am confident that there are different crisis lines that are at local VA hospitals, because we were told that they had people working at the D.C. veterans' hospital that handled that, and that it only went to the Veterans Crisis Line when they weren't open. So if you could provide, later, greater clarity, that would be helpful.

Secretary SHULKIN. What—this wouldn't be the first time that I have learned information that, then, I would agree with you. I would be confused, too.

I think I have an understanding that is clear. But, please, let's make sure that it is the correct understanding. And I do want this to be clear. There should be no doubt how a veteran gets help when they are in crisis.

And obviously, if we are not communicating that well enough, or if there is a system that I don't understand, I appreciate you raising that, and I will get back to you on this.

Ms. WASSERMAN SCHULTZ. Thank you. Especially because we——
Secretary SHULKIN. Yes.
Ms. WASSERMAN SCHULTZ [continuing]. Have lives at stake.
Secretary SHULKIN. Of course.
Ms. WASSERMAN SCHULTZ. Thank you very much.
Mr. DENT. Thank the ranking member.
At this time, I would like to recognize Mr. Fortenberry for 5 minutes.

VACANT AND UNDERUTILIZED BUILDINGS

Mr. FORTENBERRY. Thank you, Mr. Chair. And thank you again, Mr. Secretary, for listening to me earlier and, of course, embracing the transformative ideas—what I believe to—and you believe to be are transformative ideas that are kicking off in Omaha.

And in this regard, as well—Congressman Taylor actually touched on the question, and others have, as well—but back to the idea of excess inventory. For instance, the Air Force is going to come here shortly and tell us they carry 30 percent excess inventory.

And while yours is, in terms of cost impact, much, much lower, nonetheless, that is not a good use of dollars. Now, we throw around the word BRAC. I highly suggest that you do not use that term.

But what we can do is work with you, I think, constructively—maybe you already have this option in law—to, for instance, sell excess buildings to the community surrounding you. Look at the types of services which the military is starting to do—now, this is a little more applicable to bases, but nonetheless, it might apply to you—that can be contracted over—given over to local communities.

That includes like, landscape maintenance for military bases, firefighting, some security as well. These are the types of ideas that go toward the possibility of not pulling forward things that are no longer applicable in an innovative VA without running into the difficulties of impacting communities adversely when you close something.

So don't ever use the word BRAC, because it brings up a lot of bad memories. And it—you automatically set yourself up for controversy.

I have suggested to the military that we call it MISC, acronym for miscellaneous—Military Installation Savings Commission. Maybe you can work on some word—acronym like that.

But it is a, again, I think it is very consistent with what you are trying to do in terms of updating the VA.——

Secretary SHULKIN. Yes.

Mr. FORTENBERRY [continuing]. Getting the best value for the dollar, ensuring that old ways of thinking are transformed into new ways to care for veterans. And while we are pulling forward excess inventory, that just doesn't make any sense for what you are trying to do.

So those are just some final thoughts I had. I know you have covered that, when I was out of the room, more extensively. So I wanted to leave you with that.

The other issue is I think you are going to forward to us a working list of possible changes, one of which you brought up the other

day. You are in a catch-22 regarding not being able to study things that we have actually mandated——

Secretary SHULKIN. Right.

Mr. FORTENBERRY [continuing]. You to study because we have mandated you can't study things.

Secretary SHULKIN. Right.

Mr. FORTENBERRY. Ideas like that, even though they might be small—again, back to the transformative theme, we look forward to receiving those.

Secretary SHULKIN. Yes. Thank you.

Mr. FORTENBERRY. Thank you, Mr. Chair.

Mr. DENT. Seeing no further questions, I would like to thank everybody for their participation. Thank you, Dr. Shulkin.

Again, I can see why you were confirmed unanimously. Congratulations, again.

And this hearing stands adjourned. Any further subcommittee hearings will occur after the President's budget submission in late May.

Secretary SHULKIN. Thank you.

Mr. DENT. Meeting is adjourned.

[Questions for the Record submitted by Congressman Dent for The Honorable David J. Shulkin follows:]

Question: Please provide a list of all VA hospital directors; identify those positions which are without a permanent director; and the length of each vacancy.

VA Answer: Candidates have been nominated or will be announced for all Medical Center Director positions with a current vacancy. There are currently 14 Medical Center Director (MCD) positions without a permanent MCD in place. However, all 14 positions have a qualified Acting Director in place until a permanent selection is completed. Seven of the 14 MCD positions without a permanent MCD in place will be announced in National Announcement #8. Candidates have been nominated for the other seven positions and are currently being routed through the approval process. Please see the attached report for a listing of all MCD positions. The vacant positions are highlighted.

Question: Please provide a list of all the political appointee positions at the Department, identifying which ones have been filled and which have acting appointments.

MCD Report May 16 2017.xlsx

Question: Are the animal protection requirements for animals used in VA research the same as those that apply to research at the National Institutes of Health and the Department of Defense? Is every VA research lab using animals accredited by AALAC (the Association for Assessment and Accreditation of Laboratory Animal Care)?

VA Answer: Yes. VA policy requires compliance with the same U.S. Department of Agriculture (USDA) and Public Health Service (PHS) regulatory requirements that apply to research supported by the National Institutes of Health (NIH) or the Department of Defense (DoD), and VA requires that every facility where animals involved in a VA animal research program are housed or used be accredited by AAALAC.
VA applies these standards more broadly than required by law, so VA programs must meet USDA standards even for animals that are not covered by the Animal Welfare Act, and all VA animal research is overseen by the Office of Laboratory Animal Welfare (of PHS) even though most of VA animal research is not supported by NIH funds. VA policy then goes beyond those regulations to require, for example, an additional Central Office review of animal use protocols that are to be supported by VA funds, and

veterinary pre-review of all protocols (not just the more limited set required by USDA) before they are even submitted to the local oversight committee.

Question: Has the animal research conducted at the Richmond, VA medical center ever been cited by AALAC or the VA Inspector General for deficiencies in animal protection?

VA Answer: VA animal research is strictly controlled and monitored with accountability mechanisms in place that comply with the same regulations and standards that university programs, state, private, military or civilian organizations employ.
The VA Office of the Inspector General has never cited the Richmond VA Medical Center (VAMC) for deficiencies in animal protection.

The Richmond VAMC has been fully accredited by AAALAC since 1976, and similarly has no record of having had any deficiencies identified by AAALAC that would jeopardize that accreditation. Richmond has consistently earned Continuing Full Accreditation, with no mandatory items for correction.
VA is committed to meeting the highest standards of protecting animal welfare that are possible, while also supporting the responsible animal research that is necessary to reduce the human suffering and lost productivity that result from inadequate treatment. This includes self-identifying and correcting problems that come up and continuously improving the VA animal research programs.

Question: In the 'Choice successor' Request for Proposals currently out for response, what functions do you propose to bring back into VA instead of being performed by the Choice third party administrators? What are the accompanying additional VA workforce requirements?

VA Answer: The Community Care Network (CCN) Request for Proposal (RFP) brings the following functions back into the VA:

- Scheduling of Appointments for Veteran Care;
- Primary Customer service with Veterans; and
- Direct Care coordination with CCN Network Providers.

In anticipation of these incremental responsibilities, the Office of Community Care developed a Staffing Tool to quantify resource and VAMC-level staffing needs necessary to successfully operate and execute the new Operating Model in preparation for the new Community Care Network (CCN) contract. The tool incorporates average task times, workload data, position type (administrative and clinical), and approved FTEs to calculate staffing needs for each VAMC. VAMCs will be able to identify potential gaps in resource requirements by comparing their current workforce against the staffing tool estimates. The data for these estimates is not yet available, but is expected to be in the near future.

Question: What is the projected annual cost of the VA action to provide emergency mental health care to veterans who are not otherwise eligible for VA services because of a 'less than honorable' discharge?

VA Answer: The projected annual cost for emergency mental health services for former Servicemembers is estimated to be approximately $213 million in FY 2018. However, there is limited information about the health care needs and access to other health insurance for this population, so this estimate will need to be updated as this program matures. VHA will monitor actual costs and reliance on VHA for this program and update cost estimates, if needed. It is important to note that the VHA is using existing resources for this program.

Question: What is the size of the population of veterans with 'less than honorable' discharges who are not otherwise eligible for VA services.

VA Answer: It is estimated that there are a little more than 500,000 former Servicemembers with an other than honorable discharge from the military, who could be eligible for this program.

Question: What is the projected annual cost of extending Caregiver Assistance benefits to veterans who served prior to the post-9/11 era?

VA Answer: The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law (P.L.) 111-163, signed into law on May 5, 2010, provided expanded support and benefits for caregivers of eligible and covered Veterans. While the law authorized certain support services for caregivers of covered Veterans of all eras, other benefits were authorized only for qualified family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. These new benefits for approved family caregivers, provided under the Program of Comprehensive Assistance for Family Caregivers (PCAFC), include a monthly stipend paid directly to designated primary family caregivers and medical care under CHAMPVA for designated primary family caregivers who are not entitled to care or services under a health-plan contract. If the existing PCAFC were expanded to include caregivers of Veterans of all eras, VA offers the following ten year cost projections. These projections are for stipend costs only, which currently account for approximately 85 percent of costs associated with the PCAFC. These projections assume no changes to the current administration and eligibility criteria of the Program:

Year	Post 9/11 Veteran Projections	Post 9/11 Stipend Projections	Pre 9/11 Veteran Projections	Pre 9/11 Stipend Projections	Combined Post/Pre 9/11 Veterans	Combined Post/Pre Stipend Projections
2017	29,475	$447 M	58,834	$799M	88,309	$1,246M
2018	31,164	$458 M	99,207	$1564M	130,371	$2,022M
2019	32,812	$466 M	122,796	$2041M	155,608	$2,507M
2020	34,472	$501 M	131,335	$2286M	165,807	$2,787M
2021	36,164	$537 M	126,522	$2252M	162,686	$2,790M
2022	39,508	$600 M	116,234	$2116M	155,742	$2,716M
2023	41,235	$640 M	111,628	$2,079 M	152,863	$2,719M
2024	42,882	$681 M	107,287	$2,043 M	150,169	$2,725M
2025	44,524	$723 M	138,401	$2,012 M	182,925	$2,735M
2026	46,155	$767 M	136,568	$1,991 M	182,723	$2,757M
2027	47,824	$813 M	134,371	$1,973 M	182,195	$2,785M

Question: Has VA established the central whistleblower office required in section 247 of the FY17 appropriations conference bill? How does that required office comport with the new accountability and whistleblower protection office established by the April 27, 2017 executive order?

VA Answer: On May 25, 2017, VA established the Office of Accountability and Whistleblower Protection (OAWP). The functions of this office reflect the requirements of section 247 of the FY 2017 appropriations conference bill as amended by the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017. As of June 12, 2017, employees of the former Office of Accountability Review (OAR) were realigned to the new office.

Question: The Department has an RFP on the street for third party administrators for the successor program to Choice and a potential consolidation of all non-VA care programs. Since Congress has not yet enacted a successor consolidation program, why are you continuing the current RFP? Have you considered deferring it to incorporate new elements once a new program is established?

VA Answer: VHA believes it must continue with the CCN RFP acquisition to meet the current and future needs of Veterans. VHA also believes the requirements within the CCN RFP allows for enough flexibility to incorporate any additional elements once a new program is established.

Question: Based on data provided by VA, the Department had total billings in all accounts of $7.757 billion in FY2016, with $5.164 billion (67 percent) remaining uncollected. As VA's use of non-VA care grows, the share of uncollected billings seems certain to grow. If VA were able to capture more of the $5.2 billion uncollected, it would substantially improve VA's financial position as its caseload increases. Is VA considering using new techniques and new private sector partners to develop alternative mechanisms to increase its collections? Which office in VA is responsible for these collections?

VA Answer: Regardless of the gross amount billed, the Third Party payer is only responsible for paying up to **the allowable charge, net of patient responsibility**. This responsibility occurs in both the federal and commercial healthcare sectors. As a provider of care, VA cannot expect to be reimbursed at 100% of billed charges unless our charges are less than or equal to the allowable charge. Insurance plans are only obligated to reimburse VA up to their allowable charge minus patient cost sharing. In FY2016 VA collected approximately 92% of the allowed amounts from Third Party payers. Of the total amounts billed to Third Party (TP) Payers in 2016, 2.30% remained active as of January 2017.

The Veterans Access, Choice and Accountability Act of 2014 included requirements for independent assessments. These assessments resulted in recommendations from non-governmental entities with substantial private sector revenue cycle management experience. These extensive assessments of revenue operations recognized several achievements, but also provided valuable insight into opportunities for continued improvement. The outcome of the independent assessments is being used to form the basis of pilots to transform revenue collections for VHA.

VHA Office of Community Care Revenue Operations, the office responsible for these collections, utilized the findings from the report to categorize improvement opportunities that could be addressed both internally and externally. To explore best practice solutions, an industry day was conducted for vendors to propose customized improvement programs for VHA. VHA Office of Community Care Revenue Operations is currently evaluating vendor solutions for implementation to support areas highlighted in the independent assessments.

The VHA Office of Community Care also utilized the findings and recommendations from the Independent Assessment Section 201 to launch Revenue Operations Transformation Teams in February of 2017. These portfolio teams are focused on the development of process improvement initiatives and operational pilots targeting collections enhancement with in the following areas of VHA's revenue cycle:

- **Registration** – collection of insurance cards and pre-registration activities;
- **Clinical Documentation** – accurate and timely completion of clinical notes;
- **Coding** – accurate and timely coding of billable encounters;
- **Charge Capture** – consistent capture and receipt of charges;
- Billing & Collections - efficient and precise billing & collection for services; and
- **Denials** – minimized denials and optimized recoveries.

To ensure collaborative solutions, portfolios are comprised of representation from Revenue Operations and facilities, to include: VHA Health Information Management, VISNs, providers and administrative staff. The overall approach is to rapidly deliver solutions across 120 day periods. Revenue Transformation has deployed ~15 active initiatives across 49 sites. Examples of projects currently underway are: National Drug Capture, Outpatient backlog reduction utilizing Consolidated Coding and overtime coders, Clinic-

setup, High-dollar pre-registration insurance capture. The estimated impact of these portfolios is ~$104M once all activities are completed with a national roll-out. National deployment for all projects is anticipated to be completed within the next 12-18 months.

Question: We know that VA conducts its own intramural research and clinical trials on topics such as posttraumatic stress disorder, but to what degree does VA participate in privately-conducted research and trials to test medications? Does VA recruit veterans to participate in non-VA studies and share its datasets and electronic health records with private sector researchers?

VA Answer: VA does participate in industry-sponsored studies and the nature and level of participation depends on the scope of work agreed upon between VA and the private entity. These activities may include recruitment of Veterans to participate in the studies and/or looking at databases to determine the feasibility of a study and other efforts. These studies are all approved by the respective VA medical facility(ies) where the research is conducted as VA research in order to make sure they are consistent with VA's mission.

Funding provided by pharmaceutical companies for conducting these clinical trials is facilitated by VA's affiliated non-profit corporations. For FY16, $34 million in private industry support was reported by VA investigators. In privately-sponsored research including clinical trials to test the efficacy of new and/or promising drugs and devices, VA enters into research agreements such as Cooperative Research and Development Agreements (CRADAs) that address VA's responsibilities for confidentiality, privacy, study management, data use and collection, publication, and intellectual property. Data are collected once informed consent and HIPAA authorizations are obtained from a Veteran participant. They are provided to the industry partner in accordance to the terms of the authorization documents and the CRADA. Direct access to the electronic health record by private-sector researchers is not permitted.

VA's clinical and research capabilities enable it to partner in privately sponsored research in several ways. VA can serve as a coordinating entity in trials involving multiple VA sites or have multiple VA facilities participate individually in a study. Additionally, VA potentially can assist with determining the feasibility of a study within the health care system. In addition, VA Clinical Science Research and Development (CSRD) conducted an effort under its Post-Traumatic Stress Disorder (PTSD) Psychopharmacology Initiative involving a PTSD Research Industry Day on September 22, 2016 to enable early and meaningful communications with Industry or other partners on the critical need to advance evidence-based pharmacologic treatment for PTSD in Veterans. Letters of Intent were solicited to determine potential opportunities to partner on clinical trials for treating PTSD.

Question: The Committee is aware of ongoing disputes between VA and private post-secondary institutions that provide distance education programs to our veterans. The Committee also understands that such disputes may jeopardize the allotment and approval of G.I. Bill benefits to such institutions, and that veterans may not be able to participate in such programs as a result of such decisions made by VA.

As more and more universities – both public and private – explore distance and web-based learning initiatives and programming, the Committee believes that VA should be prepared to adapt as well. Please provide answers to the following questions:

a) What guidance or regulations does VA utilize to assess the merits and G.I. Bill eligibility of post-secondary institutions that utilize distance education models?

b) How does VA currently define and categorize an institute of higher education's "main campus"?

c) Does VA plan to update its regulations established under 38 C.F.R. § 21.4250 that require that an institution of higher learning be approved by the State Approving Agency where a residential course is offered ; or, for 'correspondence courses,' by the State Approving Agency for the State where the main campus is located ?

d) Does the VA currently classify for-profit institutes that operate only online campuses in multiple states differently than for-profit institutes that operate classes and programming in a brick-and-mortar campus?

Question: The VA's plan to upgrade its electronic health record and make it interoperable with Defense Department health records has been discussed in every one of our Appropriations hearings for the past decade. In that time, VA has moved from a unified DOD/VA health record to instead proposing separate records, with VA sticking to an upgrade of its existing VistA record. But you have been quoted as saying that VA should shift from VistA to a commercial system purchased from an outside contractor.

Question: What kind of an electronic health record do you envision and how will that integrate into the rest of VA's enterprise IT systems?

VA Answer: VA recognizes its need for a longitudinal electronic health record (EHR) that will assist VA in improving the veteran experience, improve employee experience, and facilitate continuous performance improvement.

On June 5, 2017, Secretary Shulkin announced that VA is authorized, through the signing of the public interest Determination and Findings (D&F), to negotiate directly with Cerner to acquire a commercial solution to replace the existing VA EHR. This effort will ultimately result in all patient data residing in one common system and enable seamless care without the manual or electronic exchange and reconciliation of data between current systems. From the Veteran perspective, having a single common

system will provide a single, accurate, lifetime health record. It will also result in improved patient care and safety.

By choosing a commercial solution, VA will ensure the EHR solution will be fully interoperable with the Department of Defense, and integrate seamlessly into community care providers that VA partners with under the Veteran Choice Program; finally VA's modernized EHR will integrate with the VA IT environment, and serve the Department well into the future.

Question: How much will this outside acquisition push back the original electronic health record completion date from October, 2018?

VA Answer: The Acquisition of VA's new electronic health record system will mirror DoD in the time from Acquisition to full deployed capability. As an interim solution, VA continues to execute the VistA Evolution upgrades that are essential for continuing to provide the Veteran with immediate and qualify healthcare and benefits.

The original completion date for VA's current iteration of the VistA Evolution Program, VistA 4, is unchanged, and will conclude in 2018. VistA 4 delivers improvements in efficiency and interoperability, and will continue VistA's award-winning legacy of providing a safe, efficient health care platform for providers and Veterans.

VistA Evolution funds have enabled investments in systems and infrastructure that support interoperability, networking and infrastructure sustainment, continuation of legacy systems, and efforts such as clinical terminology standardization. These investments are critical to the maintenance and deployment of the existing and future modernized VistA and essential to operational capability. Even with the decision to shift to a commercial EHR platform, these investments are needed, and will deliver value for Veterans and VA providers.

Question: We know that VA has used exceptions to the government-wide hiring freeze to make sure that VA medical facilities can provide care, that VA cemetery burials can continue, and that disability claims can be processed. Yet press reports last week asserted that VA is leaving thousands of positions unfilled, citing the need for a leaner VA as it develops a longer-term plan to allow more veterans to seek medical care in the private sector.

Question: Is it true that VA is initiating a staff downsizing?

VA Answer: VA has not initiated an across-the-board staff downsizing, but the Secretary has directed managers be deliberative in the hiring actions taken to ensure VA is postured for success and to improve service delivery to Veterans while identifying opportunities to reduce duplication or overlap. The Secretary has directed that VA Central Office remain under a hiring freeze as we consolidate program offices, implement shared services, and work to reduce overhead.

Question: Please identify with which State prescription drug monitoring boards VA is not sharing prescription drug prescription information, if any. Describe why VA prescription sharing has not begun for that State and the planned timeframe to begin such sharing.

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VISN /HQ	Facility	Location	VAMC Complexity Level	Vacant	Vacancy Date	Position Title	Executive Type	Incumbent	Appointed Under	Pay Plan - OccSeries - Grade	Appt Date to Current Position	Time in Current Position (Yrs)	Acting/ Detail/ Double Encumbered Name	Detail Start Date	Detail Expire Date
1	HCS Boston, MA (Jamaica Plain) (523)	Jamaica Plain, MA	1a	NO		Med Ctr Director	SES	NG, VINCENT W.	Title 5	ES-0670-0	09/08/2013	3.7			
1	HCS Central Western MA (631)	Leeds, MA	3	NO		Med Ctr Director	SES	COLLINS, JOHN P	Title 5	ES-0670-0	09/21/2014	2.7			
1	HCS Connecticut (West Haven) (689)	West Haven, CT	1a	NO		Med Ctr Director	SES	CULLITON, GERALD F	Title 5	ES-0670-0	08/11/2013	3.8			
1	HCS Maine - Togus (Augusta, ME) (402)	Togus, ME	2	NO		Med Ctr Director	SES	LILLY, RYAN S	Title 5	ES-0670-0	08/26/2012	4.8			
1	VAMC Bedford, MA (518)	Bedford, MA	3	NO		Med Ctr Director	SES	CROTEAU, CHRISTINE	Title 5	ES-0670-0	08/24/2014	2.8	ACERRA-WILLIAMS, KAREN L (Detailed)	06/20/2016	6/14/2017
1	VAMC Manchester, NH (608)	Manchester, NH	3	NO		Med Ctr Director	SES	OCKER, DANIELLE S	Title 5	ES-0670-0	12/13/2015	1.4			
1	VAMC Providence, RI (650)	Providence, RI	2	NO		Med Ctr Director	SES	MACKENZIE, SUSAN A.	Title 5	ES-0670-0	10/20/2013	3.6			
1	VAMC White River Jct, VT (405)	White River Junction, VT	2	NO		Med Ctr Director	SES	MONTOYA, ALFRED A	Title 5	ES-0670-0	06/12/2016	0.9			
2	HCS Hudson Valley, NY (620)	Montrose, NY	3	NO		Med Ctr Director	SES	CAPLAN, MARGARET B	Title 5	ES-0670-0	12/01/2013	3.4			
2	HCS New Jersey (East Orange) (561)	East Orange, NJ	1b	NO		Med Ctr Director	SES	IMMITI, VINCENT FRANK	Title 5	ES-0670-0	01/09/2017	0.3	DAVIS, MARA (Detailed)	04/01/2017	7/29/2017
2	HCS NY Harbor, NY (630)	Brooklyn, NY	1a	NO		Med Ctr Director	SES	PARAUDA, MARTINA A	Title 5	ES-0670-0	07/18/2010	6.8			
2	HCS Western NY (Buffalo) (528)	Buffalo, NY	1b	NO		Med Ctr Director	SES	STILLER, BRIAN G.	Title 5	ES-0670-0	02/26/2012	5.3			
2	VAMC Albany, NY (528D)	Albany, NY	1c	NO		Med Ctr Director	SES	GUERMONPREZ, D SCOTT	Title 5	ES-0670-0	09/18/2016	0.7			
2	VAMC Bath, NY (528A)	Bath, NY	3	YES	8/20/2016	Med Ctr Director	SES	VACANT (VICE: MICHAEL SWARTZ)		ES-0			SWARTZ, MICHAEL J (Detailed)	08/21/2016	8/15/2017
2	VAMC Bronx, NY (526)	Bronx, NY	1b	NO		Med Ctr Director	SES	LANGHOFF, ERIK	Title 38	VM-0602-15	12/02/2012	4.4			
2	VAMC Canandaigua, NY (528F)	Canandaigua, NY	3	NO		Med Ctr Director	SES	SWARTZ, MICHAEL J	Title 5	ES-0670-0	08/21/2016	0.8			
2	VAMC Northport, NY (632)	Northport, NY	1c	YES	4/1/2017	Med Ctr Director	SES	VACANT (VICE: PHILIP MOSCHITTA)		ES-0					
2	VAMC Syracuse, NY (528E)	Syracuse, NY	1b	YES	4/22/2017	Med Ctr Director	SES	VACANT (VICE: JAMES CODY)		ES-0			HAYMAN, JUDY A (Detailed)	04/22/2017	8/19/2017
4	HCS Pittsburgh, PA (646)	Pittsburgh, PA	1a	NO		Med Ctr Director	SES	MCGRAW, KARIN LOUISE	Title 5	ES-0670-0	01/10/2016	1.3			
4	VAMC Altoona, PA (503)	Altoona, PA	3	YES	2/3/2017	Med Ctr Director	SES	VACANT (VICE: WILLIAM MILLS)		ES-0			THILGES, CHARLES (Detailed)	02/16/2017	8/15/2017
4	VAMC Butler, PA (529)	Butler, PA	3	NO		Med Ctr Director	SES	CORD, DAVID P	Title 5	ES-0670-0	11/15/2015	1.5			
4	VAMC Coatesville, PA (542)	Coatesville, PA	3	NO		Med Ctr Director	SES	SIVEK, CARLA A	Title 5	ES-0670-0	11/27/2016	0.5			
4	VAMC Erie, PA (562)	Erie, PA	3	NO		Med Ctr Director	SES	GENNARO, JOHN ANTHONY	Title 5	ES-0670-0	06/12/2016	0.9			
4	VAMC Lebanon, PA (595)	Lebanon, PA	2	NO		Med Ctr Director	SES	CALLAHAN, ROBERT W.	Title 5	ES-0670-0	11/11/2007	9.5	WILSON, MARGARET G (Detailed)	11/06/2016	6/14/2017
4	VAMC Philadelphia, PA (642)	Philadelphia, PA	1b	NO		Med Ctr Director	SES	HENDEE, DANIEL D	Title 5	ES-0670-0	10/06/2013	3.6			
4	VAMC Wilkes-Barre, PA (693)	Wilkes-Barre, PA	2	NO		Med Ctr Director	SES	LLOYD, RUSSELL E	Title 5	ES-0670-0	10/02/2016	0.6			
4	VAMC Wilmington, DE (460)	Wilmington, DE	2	NO		Med Ctr Director	SES	KANE, VINCENT R	Title 5	GS-0670-15/08	05/14/2017	0.0			
5	HCS Maryland (Baltimore) (512)	Baltimore, MD	1b	NO		Med Ctr Director	SES	ROBINSON, ADAM M.	Title 38	VM-0602-15	08/23/2015	1.8			
5	VAMC Beckley, WV (517)	Beckley, WV	2	NO		Med Ctr Director	SES	VASQUEZ, STACY J	Title 5	ES-0670-0	09/18/2016	0.7			
5	VAMC Clarksburg, WV (540)	Clarksburg, WV	2	NO		Med Ctr Director	SES	SNIDER, GLENN R	Title 38	VM-0602-15	03/20/2016	1.2			
5	VAMC Huntington, WV (581)	Huntington, WV	1c	NO		Med Ctr Director	SES	NIMMO, JEFFREY B	Title 5	ES-0670-0	02/23/2014	3.3			
5	VAMC Martinsburg, WV (613)	Martinsburg, WV	1c	NO		Med Ctr Director	SES	COOKE, TIMOTHY J.	Title 5	ES-0670-0	06/01/2014	2.9			
5	VAMC Washington, DC (688)	Washington, DC	1a	NO		Med Ctr Director	SES	HAWKINS, BRIAN A.	Title 5	ES-0670-0	09/25/2011	5.7			
6	VAMC Asheville, NC (637)	Asheville, NC	1c	NO		Med Ctr Director	SES	BREYFOGLE, CYNTHIA L	Title 5	ES-0670-0	04/11/2010	7.1			
6	VAMC Durham, NC (558)	Durham, NC	1a	NO		Med Ctr Director	SES	SEEKINS, DEANNE M	Title 5	ES-0670-0	06/17/2012	4.9			
6	VAMC Fayetteville, NC (565)	Fayetteville, NC	2	NO		Med Ctr Director	SES	GOOLSBY, ELIZABETH B	Title 5	ES-0670-0	07/04/2010	6.8			
6	VAMC Hampton, VA (590)	Hampton, VA	1c	YES	1/6/2017	Med Ctr Director	SES	VACANT (VICE: MIKE DURFEE)		ES-0			LOMBARDO, ALAN J (Detailed)	03/12/2017	7/9/2017
6	VAMC Richmond, VA (652)	Richmond, VA	1a	NO		Med Ctr Director	SES	BRANDECKER, JOHN A	Title 5	ES-0670-0	05/05/2013	4.0			
6	VAMC Salem, VA (658)	Salem, VA	1c	NO		Med Ctr Director	SES	STACKHOUSE, REBECCA J	Title 5	ES-0670-0	10/02/2016	0.6			
6	VAMC Salisbury, NC (659)	Salisbury, NC	1c	NO		Med Ctr Director	SES	GREEN, EMILIE KAYE	Title 5	ES-0670-0	10/21/2012	4.6			
7	HCS Central AL (Montgomery) (619)	Montgomery, AL	2	NO		Med Ctr Director	SES	BOYLE, LINDA L	Title 5	ES-0670-0	11/27/2016	0.5			
7	VAMC Atlanta, GA (Decatur) (508)	Atlanta, GA	1a	NO		Med Ctr Director	SES	WALKER, ANNETTE P	Title 5	ES-0670-0	09/04/2016	0.7			
7	VAMC Augusta, GA (509)	Augusta, GA	1a	YES	4/1/2017	Med Ctr Director	SES	VACANT (VICE: MARIA ANDREWS)		ES-0			JACKSON, ROBIN E (Detailed)	04/01/2017	7/28/2017
7	VAMC Birmingham, AL (521)	Birmingham, AL	1a	NO		Med Ctr Director	SES	SMITH, THOMAS C.	Title 5	ES-0670-0	05/18/2013	4.0			
7	VAMC Charleston, SC (534)	Charleston, SC	1b	NO		Med Ctr Director	SES	ISAACKS, SCOTT RUSSELL	Title 5	ES-0670-0	11/02/2014	2.5			
7	VAMC Columbia, SC (544)	Columbia, SC	1c	NO		Med Ctr Director	SES	OMURA, DAVID L	Title 5	ES-0670-0	03/19/2017	0.2			
7	VAMC Dublin, GA (557)	Dublin, GA	3	NO		Med Ctr Director	SES	MORRO, MARYALICE	Title 5	ES-0670-0	03/22/2015	2.2			

7	VAMC Tuscaloosa, AL (679)	Tuscaloosa, AL	3	NO		Med Ctr Director	SES	MERKLE, JOHN F	Title 5	ES-0670-0	09/20/2015	1.7				
8	HCS Miami, FL (546)	Miami, FL	1a	NO		Med Ctr Director	SES	RUSSO, PAUL MICHAEL	Title 5	ES-0670-0	05/20/2012	5.0				
8	HCS North Florida-South Georgia (Gainesville, FL) (573)	Gainesville, FL	1a	NO		Med Ctr Director	SES	WISNIESKI, THOMAS JOSEPH	Title 5	ES-0670-0	06/03/2012	4.9				
8	HCS San Juan, PR (672)	San Juan, PR	1a	YES	1/10/2017	Med Ctr Director	SES	VACANT (VICE: DEWAYNE HAMLIN)		ES-0			SANCHEZ, ANTONIO (Detailed)	01/25/2017	5/25/2017	
8	VAMC Bay Pines, FL (516)	Bay Pines, FL	1a	NO		Med Ctr Director	SES	KLINKER, SUZANNE MARIE	Title 5	ES-0670-0	05/20/2012	5.0				
8	VAMC Orlando, FL (675)	Orlando, FL	1c	NO		Med Ctr Director	SES	LIEZERT, TIMOTHY W.	Title 5	ES-0670-0	08/06/2006	10.8	COLE, KATHLEEN L. (Detailed)	03/21/2017	7/18/2017	
8	VAMC Tampa, FL (673)	Tampa, FL	1a	NO		Med Ctr Director	SES	BATTLE, JOE D.	Title 5	ES-0670-0	07/26/2015	1.8				
8	VAMC West Palm Beach, FL (548)	West Palm Beach, FL	1c	NO		Med Ctr Director	SES	KATSH-BANENSKY, DONNA	Title 5	ES-0670-0	02/21/2017	0.3				
9	HCS TN Valley (Nashville) (626)	Nashville, TN	1a	NO		Med Ctr Director	SES	VEDRAL-BARON, JENNIFER L.	Title 5	ES-0670-0	09/04/2016	0.7				
9	VAMC Lexington, KY (596)	Lexington, KY	1b	NO		Med Ctr Director	SES	METCALF, EMMA M	Title 5	ES-0670-0	08/10/2013	3.8				
9	VAMC Louisville, KY (603)	Louisville, KY	1c	NO		Med Ctr Director	SES	TRAXLER, MARTIN JAY	Title 5	ES-0670-0	11/30/2014	2.5				
9	VAMC Memphis, TN (614)	Memphis, TN	1a	NO		Med Ctr Director	SES	DUNNING, DAVID K.	Title 5		05/14/2017	0.0				
9	VAMC Mountain Home, TN (621)	Mountain Home, TN	1c	NO		Med Ctr Director	SES	BORGOS, DEAN	Title 5	ES-0670-0	01/08/2017	0.3				
10	ACC Columbus, OH (757)	Columbus, OH	2	NO		Med Ctr Director	SES	HEPKER, WENDY J.	Title 5	ES-0670-0	03/20/2016	1.2				
10	HCS Northern Indiana (Ft. Wayne) (610)	Fort Wayne, IN	2	NO		Med Ctr Director	SES	HERSHMAN, MICHAEL E.	Title 5	ES-0670-0	09/04/2016	0.7				
10	VAMC Ann Arbor, MI (506)	Ann Arbor, MI	1a	YES	11/12/2016	Med Ctr Director	SES	VACANT (VICE: ROBERT MCDIVITT)		ES-0			SKUPIEN, MARY BETH C. (Detailed)	10/23/2016	6/20/2017	
10	VAMC Battle Creek, MI (515)	Battle Creek, MI	3	NO		Med Ctr Director	SES	SKUPIEN, MARY BETH C.	Title 5	ES-0670-0	11/04/2012	4.5	DORNOFF, EDWARD G (Detailed)	02/20/2017	6/20/2017	
10	VAMC Chillicothe, OH (538)	Chillicothe, OH	2	YES	1/1/2017	Med Ctr Director	SES	VACANT (VICE: J SULLIVAN)		ES-0			MURDOCK, MARK (Detailed)	01/04/2017	5/27/2017	
10	VAMC Cincinnati, OH (539)	Cincinnati, OH	1b	NO		Med Ctr Director	SES	MUTSON, VIVIAN T	Title 5	ES-0670-0	10/02/2016	0.6				
10	VAMC Cleveland, OH (541)	Cleveland, OH	1a	NO		Med Ctr Director	SES	FUEHRER, SUSAN MARIE	Title 5	ES-0670-0	09/26/2010	6.7				
10	VAMC Dayton, OH (552)	Dayton, OH	1c	NO		Med Ctr Director	SES	COSTIE, GLENN A.	Title 5	ES-0670-0	12/18/2011	5.4				
10	VAMC Detroit, MI (553)	Detroit, MI	1c	NO		Med Ctr Director	SES	REEVES, PAMELA J.	Title 38	VM-0602-15	03/30/2008	9.2				
10	VAMC Indianapolis, IN (583)	Indianapolis, IN	1a	NO		Med Ctr Director	SES	HANCOCK, JAMES BRIAN	Title 38	VM-0602-15	05/01/2016	1.0				
10	VAMC Saginaw, MI (655)	Saginaw, MI	3	NO		Med Ctr Director	SES	CREASMAN, GINNY L.	Title 5	ES-0670-0	07/24/2016	0.8				
12	FHCC Captain James A. Lovell (N Chicago, IL) (556)	North Chicago, IL	1c	NO		Med Ctr Director	SES	HOLT, STEPHEN R	Title 38	VM-0602-15	10/05/2014	2.6				
12	VAMC Chicago, IL (537)	Chicago, IL	1b	NO		Med Ctr Director	SES	MAGILL, MARC A	Title 5	ES-0670-0	11/27/2016	0.5				
12	VAMC Danville, IL (550)	Danville, IL	3	NO		Med Ctr Director	SES	YOUNG, STEPHANIE	Title 5	ES-0670-0	06/12/2016	0.9				
12	VAMC Hines, IL (578)	Hines, IL	1a	NO		Med Ctr Director	SES	BRAVERMAN, STEVEN EDWARD	Title 38	VM-0602-15	09/18/2016	0.7				
12	VAMC Iron Mountain, MI (585)	Iron Mountain, MI	3	NO		Med Ctr Director	SES	RICE, JAMES WILLIAM	Title 5	ES-0670-0	04/10/2011	6.1				
12	VAMC Madison, WI (607)	Madison, WI	1b	NO		Med Ctr Director	SES	ROHRER, JOHN J	Title 5	ES-0670-0	01/10/2016	1.3				
12	VAMC Milwaukee, WI (695)	Milwaukee, WI	1a	NO		Med Ctr Director	SES	ZOMCHEK, DANIEL S	Title 5	ES-0670-0	06/26/2016	0.9				
12	VAMC Tomah, WI (676)	Tomah, WI	3	NO		Med Ctr Director	SES	BRAHM, VICTORIA P.	Title 5	ES-0670-0	02/05/2017	0.3				
15	HCS Eastern Kansas (589EA)	Topeka, KS	1c	NO		Med Ctr Director	SES	KLOPFER, A. RUDY	Title 5	ES-0670-0	10/07/2012	4.6				
15	HCS St. Louis, MO (657)	St. Louis, MO	1a	NO		Med Ctr Director	SES	REPKO, KEITH D	Title 5	ES-0670-0	10/02/2016	0.6				
15	VAMC Columbia, MO (589CA)	Columbia, MO	1c	NO		Med Ctr Director	SES	ISAACKS, DAVID B	Title 5	ES-0670-0	06/26/2016	0.9				
15	VAMC Kansas City, MO (589)	Kansas City, MO	1b	NO		Med Ctr Director	SES	FOGARTY, KATHLEEN R.	Title 5	ES-0670-0	03/08/2015	2.2				
15	VAMC Marion, IL (657MA)	Marion, IL	2	NO		Med Ctr Director	SES	GINSBERG, JO-ANN M	Title 5	ES-0670-0	09/18/2016	0.7				
15	VAMC Poplar Bluff, MO (657PA)	Poplar Bluff, MO	3	NO		Med Ctr Director	SES	HALL, PATRICIA L	Title 5	ES-0670-0	01/10/2016	1.3				
15	VAMC Wichita, KS (589WA)	Wichita, KS	1c	NO		Med Ctr Director	SES	AMENT, RICKY A.	Title 5	ES-0670-0	12/11/2016	0.4				
16	HCS Central Arkansas (Little Rock) (598)	Little Rock, AR	1a	NO		Med Ctr Director	SES	SCOTT, MARGIE A	Title 38	VM-0602-15	09/01/2016	1.0				
16	HCS Gulf Coast Veterans (Biloxi, MS) (520)	Biloxi, MS	1c	NO		Med Ctr Director	SES	DAWSON, ANTHONY L.	Title 5	ES-0670-0	09/23/2012	4.7				
16	HCS of the Ozarks, Fayetteville, AR (564)	Fayetteville, AR	2	NO		Med Ctr Director	SES	MATTHEWS, BRYAN C	Title 5	ES-0670-0	01/10/2016	1.3				
16	HCS Southeast LA (New Orleans) (629)	New Orleans, LA	1b	NO		Med Ctr Director	SES	RIVERA, FERNANDO OSCAR	Title 5	ES-0670-0	01/11/2015	2.3				
16	VAMC Alexandria, LA (502)	Alexandria, LA	3	NO		Med Ctr Director	SES	DANCY, PETER C	Title 5	ES-0670-0	01/24/2016	1.3				
16	VAMC Houston, TX (580)	Houston, TX	1a	NO		Med Ctr Director	SES	VAZQUEZ, FRANCISCO	Title 5	ES-0670-0	08/21/2016	0.8				
16	VAMC Jackson, MS (586)	Jackson, MS	1b	NO		Med Ctr Director	SES	WALKER, DAVID M.	Title 38	VM-0602-15	12/13/2015	1.4				
16	VAMC Shreveport, LA (667)	Shreveport, LA	1c	YES	5/10/2017	Med Ctr Director	SES	VACANT (VICE: TOBY MATHEW)		ES-0			CROCKETT, RICHARD L. (Detailed)	02/06/2017	6/6/2017	
17	HCS Amarillo, TX (504)	Amarillo, TX	2	NO		Med Ctr Director	SES	KIEFER, MICHAEL L	Title 5	ES-0670-0	11/01/2015	1.5				
17	HCS Central Texas (Temple) (674)	Temple, TX	1b	NO		Med Ctr Director	SES	SANDLES, CHRISTOPHER R	Title 5	ES-0670-0	02/19/2017	0.3				
17	HCS El Paso, TX (756)	El Paso, TX	3	NO		Med Ctr Director	SES	AMARAL, MICHAEL L	Title 5	ES-0670-0	11/13/2016	0.5				

17	HCS North Texas (Dallas) (549)	Dallas, TX	1a	YES	4/30/2017	Med Ctr Director	SES	VACANT (VICE: JEFF MILLIGAN)		ES-0			BROWN, KENDRICK D. (Detailed)	05/01/2017	8/29/2017
17	HCS South Texas (San Antonio) (671)	San Antonio, TX	1a	NO		Med Ctr Director	SES	WALTON, ROBERT M	Title 5	ES-0670-0	11/15/2015	1.5			
17	HCS Texas Valley Coastal Bend (Harlingen) (740)	Harlingen, TX	3	NO		Med Ctr Director	SES	PEREZ, JOSE A	Title 5	ES-0670-0	10/16/2016	0.6			
17	HCS West Texas HCS (Big Spring) (519)	Big Spring, TX	3	NO		Med Ctr Director	SES	JANGDHARI, KALAUTIE SITA	Title 5	ES-0670-0	12/11/2016	0.4			
19	HCS Eastern CO (Denver) (554)	Denver, CO	1a	NO		Med Ctr Director	SES	HOUSER-HANFELDER, SALLIE ANN	Title 5	ES-0670-0	01/10/2016	1.3			
19	HCS Montana (Ft Harrison) (436)	Fort Harrison, MT	2	NO		Med Ctr Director	SES	BERGER, KATHY W.	Title 5	ES-0670-0	12/11/2016	0.4			
19	HCS Oklahoma City, OK (635)	Oklahoma City, OK	1a	NO		Med Ctr Director	SES	VLOSICH, KRISTOPHER W	Title 5	ES-0670-0	06/12/2016	0.9			
19	HCS Salt Lake City, UT (660)	Salt Lake City, UT	1a	YES	11/28/2016	Med Ctr Director	SES	VACANT (VICE: STEVEN YOUNG)		ES-0			STOVALL, SHELLA D. (Detailed)	01/26/2017	5/23/2017
19	VAMC Cheyenne, WY (442)	Cheyenne, WY	2	NO		Med Ctr Director	SES	ROBERTS, PAUL L	Title 5	ES-0670-0	06/26/2016	0.9			
19	VAMC Grand Junction, CO (575)	Grand Junction, CO	2	NO		Med Ctr Director	SES	KILMER, MICHAEL T	Title 5	ES-0670-0	04/16/2017	0.1			
19	VAMC Muskogee, OK (623)	Muskogee, OK	2	NO		Med Ctr Director	SES	MORGAN, MARK E	Title 5	ES-0670-0	06/12/2016	0.9			
19	VAMC Sheridan, WY (666)	Sheridan, WY	3	YES	12/10/2016	Med Ctr Director	SES	VACANT (VICE: KATHY BERGER)		ES-0			BERGER, KATHY W. (Detailed)	02/05/2017	6/5/2017
20	HCS Alaska (Anchorage) (463)	Anchorage, AK	3	NO		Med Ctr Director	SES	BALLARD, TIMOTHY D.	Title 38	VM-0602-15	07/11/2016	0.8			
20	HCS Portland, OR (648)	Portland, OR	1a	NO		Med Ctr Director	SES	FISHER, MICHAEL W.	Title 5	ES-0670-0	07/24/2016	0.8			
20	HCS Puget Sound, WA (663)	Seattle, WA	1a	NO		Med Ctr Director	SES	TADYCH, MICHAEL C	Title 5	GS-0670-15/04	04/30/2017	0.1			
20	HCS Roseburg, OR (653)	Roseburg, OR	3	NO		Med Ctr Director	SES	PAXTON, DOUGLAS V	Title 5	ES-0670-0	05/03/2015	2.0			
20	SORCC White City, OR (692)	White City, OR	3	NO		Med Ctr Director	SES	DIONNE, PHILIP G	Title 5	ES-0670-0	10/19/2015	1.6			
20	VAMC Boise,ID (531)	Boise, ID	2	ND		Med Ctr Director	SES	WOOD, DAVID P.	Title 5	ES-0670-0	04/22/2012	5.1			
20	VAMC Spokane, WA (668)	Spokane, WA	3	NO		Med Ctr Director	SES	JOHNSON, JAMES RONALD	Title 5	ES-0670-0	02/07/2016	1.3			
20	VAMC Walla Walla, WA (687)	Walla Walla, WA	3	NO		Med Ctr Director	SES	WESTFALL, BRIAN WENDELL	Title 5	ES-0670-0	05/23/2010	7.0			
21	HCS Central California (Fresno) (570)	Fresno, CA	2	NO		Med Ctr Director	SES	BAUMAN, STEPHEN R	Title 5	ES-0670-0	11/15/2015	1.5			
21	HCS Northern California (Mather) (612)	Mather, CA	1b	NO		Med Ctr Director	SES	STOCKWELL, DAVID R	Title 5	ES-0670-0	10/20/2013	3.6			
21	HCS Pacific Islands (Honolulu, HI) (459)	Honolulu, HI	3	NO		Med Ctr Director	SES	GUTOWSKI, JENNIFER SUSAN	Title 5	GS-0670-15/05	05/14/2017	0.0			
21	HCS Palo Alto, CA (640)	Palo Alto, CA	1a	YES	6/10/2016	Med Ctr Director	SES	VACANT (VICE: ELIZABETH FREEMAN)		ES-0			MARTINEZ, GLORIA N (Detailed)	02/10/2017	6/9/2017
21	HCS San Francisco, CA (662)	San Francisco, CA	1a	NO		Med Ctr Director	SES	GRAHAM, BONNIE SUE	Title 5	ES-0670-0	08/25/2013	3.8			
21	HCS Sierra Nevada (Reno) (654)	Reno, NV	1c	NO		Med Ctr Director	SES	HOWARD, LISA M	Title 5	ES-0670-0	06/14/2015	1.9			
21	HCS Southern Nevada (N Vegas) (593)	North Las Vegas, NV	1c	NO		Med Ctr Director	SES	KEARNS, PEGGY W	Title 5	ES-0670-0	12/27/2015	1.4			
22	HCS Greater Los Angeles, CA (691)	Los Angeles, CA	1a	NO		Med Ctr Director	SES	BROWN, ANN R	Title 5	ES-0670-0	02/07/2016	1.3			
22	HCS Loma Linda, CA (605)	Loma Linda, CA	1b	NO		Med Ctr Director	SES	FALLEN, BARBARA L.	Title 5	ES-0670-0	06/30/2013	3.9			
22	HCS Long Beach, CA (600)	Long Beach, CA	1b	NO		Med Ctr Director	SES	DANNENBERG, WALT C	Title 5	ES-0670-0	02/05/2017	0.3			
22	HCS New Mexico (Albuquerque) (501)	Albuquerque, NM	1a	NO		Med Ctr Director	SES	WELCH, ANDREW M.	Title 5	ES-0670-0	12/14/2014	2.4			
22	HCS Northern AZ (Prescott) (649)	Prescott, AZ	3	NO		Med Ctr Director	SES	OENCKE, BARBARA A	Title 5	ES-0670-0	03/05/2017	0.2			
22	HCS Phoenix, AZ (644)	Phoenix, AZ	1b	NO		Med Ctr Director	SES	NELSON, RIMAANN O.	Title 5	ES-0670-0	10/02/2016	0.6			
22	HCS San Diego, CA (664)	San Diego, CA	1a	NO		Med Ctr Director	SES	SMITH, ROBERT M	Title 38	VM-0602-15	07/24/2016	0.8			
22	HCS Southern AZ (Tucson) (678)	Tucson, AZ	1a	NO		Med Ctr Director	SES	CARON, WILLIAM J	Title 5	ES-0670-0	03/05/2017	0.2			
23	HCS Black Hills, SD (568)	Fort Meade, SD	2	NO		Med Ctr Director	SES	HORSMAN, SANDRA L	Title 5	ES-0670-0	08/23/2015	1.8			
23	HCS Central Iowa (Des Moines) (636D)	Des Moines, IA	1c	NO		Med Ctr Director	SES	GRAHAM, GAIL	Title 5	ES-0670-0	07/10/2016	0.8			
23	HCS Fargo, ND (437)	Fargo, ND	2	NO		Med Ctr Director	SES	LIVERSAGE, LAVONNE K	Title 5	ES-0670-0	11/17/2013	3.5			
23	HCS Iowa City, IA (636I)	Iowa City, IA	1b	NO		Med Ctr Director	SES	JOHNSON-MEKOTA, JUDITH LYNN	Title 5	ES-0670-0	02/08/2015	2.3			
23	HCS Minneapolis, MN (618)	Minneapolis, MN	1a	NO		Med Ctr Director	SES	KELLY, PATRICK J	Title 5	ES-0670-0	05/19/2013	4.0			
23	HCS Nebraska-Western Iowa (Omaha, NE) (636)	Omaha, NE	1b	NO		Med Ctr Director	SES	BURMAN, B DON	Title 5	ES-0670-0	03/01/2015	2.2			
23	HCS Sioux Falls, SD (438)	Sioux Falls, SD	2	NO		Med Ctr Director	SES	GOODSPEED, DARWIN G	Title 5	ES-0670-0	12/01/2013	3.4			
23	HCS St. Cloud, MN (656)	St. Cloud, MN	3	NO		Med Ctr Director	SES	BLACK, STEPHEN D	Title 5	ES-0670-0	04/02/2017	0.1			

[Questions for the Record submitted by Congressman Rooney for The Honorable David J. Shulkin follows:]

Question: There is currently an ongoing court case between the Department of Veterans Affairs and veterans seeking payment for treatments they received at non-VA emergency rooms. Many of those veterans had valid medical emergencies and were directed to go to the ER by the VA. The law requires the VA to pay for emergency treatment of non-service connected conditions if there's not a third party responsible for covering the full cost of care. The law also includes limitations on reimbursements and a number of qualifying conditions.

- Are veterans who are eligible for these reimbursements receiving them?
- If the court decides against your department on this matter, what is the projected cost and how do you plan to provide all eligible veterans with reimbursements?

VA Answer: VA pays/reimburses claims for the reasonable value of eligible Veterans' cost of emergency treatment furnished in the community for their non-service connected conditions if all applicable eligibility criteria in 38 U.S.C. § 1725 are met.

As to the court case alluded to in your incoming question, based on the parties' joint application, the U.S. Court of Appeals for the Federal Circuit dismissed the Department's appeal on July 17, 2017, of a precedential decision issued by the U.S. Court of Veterans Claims (CAVC) on April 8, 2016, in which the CAVC set aside 38 C.F.R. § 17.1002(f) based on its interpretation of § 1725. VA is still in the process of promulgating regulations needed to adjudicate claims affected by the CAVC April 8 decision, which essentially makes VA a secondary payer to an otherwise eligible Veteran's health-plan contract (first payer). In the interim, we continue to advise Veterans and community providers to submit their claims for first party payment/reimbursement for the costs of emergency treatment to the Veterans' health-plan contracts, to ensure they meet applicable claims filing deadlines. This is also required to accurately identify VA's reimbursement/payment obligation as secondary payer under the law (assuming all other eligibility criteria have been met). The terms of § 1725 still, however, bar VA from reimbursing/paying any copayment or similar payment for which a Veteran is responsible under the Veteran's health-plan contract.

Question: Our country is facing the worst drug crisis in its history. In your testimony, you note that you've conducted 49 investigations resulting in charges related to illicit drug activity to 55 individuals. A recently released GAO report has detailed a lack of oversight and accountability at VA hospitals, specifically related to substance inspection programs. The report indicates that one VA facility missed 43 percent of its monthly inspections in critical patient care areas and the pharmacy over the course of a year. At two of three facilities reviewed, inspectors did not properly verify that controlled substances had been transferred from VA pharmacies to patient care areas. Recent news reports have highlighted this problem in Florida, noting that hundreds of doses of fentanyl and other powerful prescription drugs have been lost or stolen from a number of Florida VA hospitals or facilities.

Question: One of the employees implicated in the missing drugs was a nurse who was working in Miami—she was allowed to resign rather than be fired. Are you making any changes to the hiring process to ensure that these types of employees are not hired in the future?

VA Answer: The Department of Veterans Affairs (VA) is not currently making changes to the hiring process. However, the VA takes several measures to ensure employees and prospective employees are suitable for government service.

Drug Testing: In accordance with criteria contained in Executive Order 12564, VA Directive 5383 and VA Handbook 5383 identify positions that the Secretary of the VA has determined as "sensitive" for drug testing purposes which are designated as subject to drug testing of various types including Random Testing; Reasonable Suspicion Testing; Injury, Illness, Unsafe, or Unhealthful Practice Testing, and Applicant Testing. Beginning March 1, 2016, VA began testing 100% of all applicants tentatively selected for VA employment in testing designated positions.

Positive Test Results: In the event that an employee tests positive during a drug test, VA Directive 5383 mandates immediate administrative action, including referring an employee found to use illegal drugs to the Employee Assistance Program (EAP), and, if the employee occupies a sensitive position, immediately relieving the employee from that position without regard to whether it is a testing designated position. Additionally, VA Directive 5383 outlines potential disciplinary actions that are consistent with the Executive Order, and includes the full range of disciplinary actions, including removal.

Suitability Measures: In determining whether a person is suitable for Federal employment, the following factors will be considered as basis for finding a person unsuitable and taking a suitability action:

1. Misconduct or negligence in employment;
2. Criminal or dishonest conduct;
3. Material, intentional false statement, or deception or fraud in examination or appointment;
4. Refusal to furnish testimony as required by § 5.4 of this chapter;
5. Alcohol abuse, without evidence of substantial rehabilitation, of a nature and duration that suggests that the applicant or appointee would be prevented from performing the duties of the position in question, or would constitute a direct threat to the property or safety of the applicant or appointee or others;
6. Illegal use of narcotics, drugs, or other controlled substances without evidence of substantial rehabilitation;
7. Knowing and willful engagement in acts or activities designed to overthrow the U.S. Government by force; and
8. Any statutory or regulatory bar which prevents the lawful employment of the person involved in the position in question.

Additionally, there is a provision in the Choice Act that requires the Secretary for Veterans Affairs to report to Congress the number of health care providers who left the Department and were subsequently rehired by the Department. This is an additional safeguard that is in place as rehires are monitored, in addition to the reason(s) for their initial separation.

Also, please note that the reference to 49 investigations stated in the question does not appear to be related to the background investigation or suitability process, but appears to be an internal investigation related to controlled substances being stolen. If so, if these individuals apply for positions with VA in future, they will need to disclose any resignation that occurred in lieu of termination as well as any criminal charges resulting in conviction.

Question: A recent GAO report mentioned that one hospital had appointed a special coordinator to oversee substance inspections, which seem to have improved outcomes at that facility. Is this something that could be applied system-wide? Are there any other localized "best practices" that you've come across that can help improve your substance inspection programs?

VA Answer: The GAO report recommended an Alternate Controlled Substance Coordinator (CSC) be appointed as an additional control procedure. VA accepted this recommendation and on 2/22/2017 directed all VHA facilities to appoint an Alternate CSC within 60 days.

Question: What other efforts are you taking to ensure that staff follows existing protocol to prevent substance diversion?

VA Answer: VA has taken a number of steps to ensure compliance with national policy and provide oversight of medical facility inspection programs as recommended in the GAO report. For example, on February 22, 2017 the Deputy Under Secretary for Health for Operations and Management issued a memorandum to VISN and Facility Directors directing (1) a comparison of facility policy to national requirements to ensure all requirements are followed; (2) a multi-disciplinary review of the controlled substance inspection program using a standardized assessment guide, (3) Incorporation of inspection program reports into the facility Quality Management committee for adherence to program requirements and to ensure any corrective actions needed are followed through to completion and (4) VISN oversight to ensure facilities are in compliance. These recommendations have also been added to the national policy to ensure ongoing compliance. The updated policy, VHA Directive 1108.02(1) Inspection of Controlled Substances, was published on March 6, 2017 and can be located at: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=4301.

The West Palm Beach VA Medical Center (WPB VAMC) recently conducted a study and determined that the veterans rural health clinics in Moore Haven and Clewiston were underutilized. The WPB VAMC is discussing the possibility of closing both of these veterans clinics.

Question: How will the veterans who use these clinics, many of them elderly, be impacted by these closures?

VA Answer: After reviewing the proposal, VHA Leadership made the determination to keep the Clewiston and Moore Haven Rural Health Clinics open. The clinics will operate for a combined three (3) days per week continuing to serve Veterans in the rural western regional of the West Palm Beach VAMC catchment area.

Question: Which community providers would serve these veterans?

VA Answer: After reviewing the proposal, VHA Leadership made the determination to keep the Clewiston and Moore Haven Rural Health Clinics open. The clinics will operate for a combined three (3) days per week continuing to serve Veterans in the rural western regional of the West Palm Beach VAMC catchment area.

Question: What nearby veterans facilities can these veterans utilize?

VA Answer: The Okeechobee CBOC is 86.5 miles from Clewiston and 41 miles from Moore Haven; the Sebastian CBOC is located 74 miles from Clewiston and 55 miles from Moore Haven. The West Palm Beach VA is approximately 85 miles from both locations. After reviewing the proposal, VHA Leadership made the determination to keep the Clewiston and Moore Haven Rural Health Clinics open. The clinics will operate for a combined three (3) days per week continuing to serve Veterans in the rural western regional of the West Palm Beach VAMC catchment area.

Question: How do those facilities plan to facilitate potentially hundreds of new patients?

VA Answer: After reviewing the proposal, VHA Leadership made the determination to keep the Clewiston and Moore Haven Rural Health Clinics open. The clinics will operate for a combined three (3) days per week continuing to serve Veterans in the rural western regional of the West Palm Beach VAMC catchment area.

Question: In discussions regarding the closure of these clinics, is the VAMC considering closing one clinic and then reevaluating usage? If not, will the VAMC make these considerations a part of their discussion?

VA Answer: The clinics are situated in the remote Western region of the West Palm Beach catchment area and both clinics operate only part-time. With a combined enrollment of 300, the demand represents 25% of a typical caseload for a primary care provider. Further, options to expand services or allow for additional opportunities using Telehealth are limited as the infrastructure does not exist to support the technology. The

decision to close both clinics was based upon utilization, quality and access to services in the region. Utilization of Choice and/or established Community Based Outpatient Clinics allows for five-day per week access to comprehensive Primary Care Services.

[Questions for the Record submitted by Congressman Valadao for The Honorable David J. Shulkin follows:]

Question: Mr. Secretary, thank you for taking the time to join us today. My district in California is serviced by two VA regional offices. Recently, while meeting with one of my regional office Directors they expressed concern with the Vocational Rehabilitation and Employment program. Voc Rehab is an important program which helps to assist veterans in finding proper training for jobs after they transition to civilian life. While this program is seen as essential to helping service connected veterans receive the support they earned the recent surge in veterans applying to be a part of the program has resulted in the program's inability to meet demand for a number of reasons. The VA has not increased full time equivalent allocations for counselors in several budgets. This issue impacts many of my constituents and, given the positive impact the program has on veterans, I am concerned. These staffing shortages with the program are leading to a backlog of veterans who are unable to take part in the program for months and I do not want to see the VA in another backlog situation as we experienced in years past. In addition, with increased caseloads VA employees are being asked to do more with the same or less resources. Are you aware of this issue and is the VA in the process of addressing this?

VA Answer: VBA is aware of the caseload and administrative burdens placed on our Vocational Rehabilitation Counselors (VRC). We are utilizing several mechanisms to address these issues. Vocational Rehabilitation and Employment (VR&E) Service has developed and implemented national service contracts that provide contracted support for CH 31 and CH36 services at all Regional Offices. VR&E anticipates supporting approximately $4M in contracted services this fiscal year, which will help lower effective caseloads for VRCs. Additionally, VBA is continually looking at system and process improvements that will reduce administrative burden on counselors. Current efforts include developing a new case management system and examining ways to centralize administrative tasks like invoice processing.

a. Follow up: How do you plan to support my Regional Directors who have been tasked with executing all claims in a timely manner?

VA Answer: VBA's Regional Office Directors are expected to foster innovative and effective work environments that maximize employee potential, reflect VBA's organizational mission and values, and result in timely processing for all Veterans. Directors are supported in this mission through a robust program that includes both leadership development and technical support. Primarily, the National Work Queue (NWQ) is designed to assist with nationwide timely processing of all claims. NWQ routes work to stations daily, based on available resources and skill sets. It ensures an equitable distribution of claims based on each station's available resources and national performance standards and national pending inventory. NWQ maximized VBA's performance at both individual and national levels: by aligning distributed work with available resources, NWQ positions Directors for success at the local level, while maintaining focus on nationwide goals and priorities for the Agency. The NWQ team works closely with regional offices to ensure NWQ routing continues to meet the needs of each office.

[Questions for the Record submitted by Congressman Jenkins for The Honorable David J. Shulkin follows:]

Question: Opioid Epidemic:

Can you please specify a few of the VA's efforts to address the opioid epidemic, chronic pain issues for veterans, and on the VA's recent efforts to implement the Comprehensive Addiction and Recovery Act.

VA Answer: VA initiated a multi-faceted approach to addressing both the opioid epidemic and chronic pain issues called the Opioid Safety Initiative (OSI). The goal of OSI is to reduce over-reliance on opioid analgesics for pain management and to promote safe and effective use of opioid therapy when clinically indicated.
The OSI is a comprehensive strategy that includes education of providers and expanded access to non-pharmacological treatment options, in particular behavioral and complementary integrative health modalities. The OSI makes the totality of opioid use visible within VA. OSI is a comprehensive approach to improve the quality of life for the hundreds of thousands of Veterans suffering from chronic pain.

OSI is focused on:

- Lowering dependency on this class of drugs by incorporating a team approach
- Reducing opioid use by alleviating a Veterans' pain using non-prescription methods.
- Implementing a set of opioid risk mitigation strategies for Veterans receiving opioid medication for pain, to allow prescribing in the safest way possible.
- Educating Veterans and providing tools to better manage their pain with a decreased or even eliminated use of opioid including:
    - Patient/Family Management toolkit in the Veteran's Health Library
    - Methods of pain management such as physical therapy; close patient monitoring with frequent feedback; and complementary and alternative medicine practices like acupuncture and yoga,
    - Pain management app called Pain Coach which is available for download by patients receiving pain management treatments
    - My HealtheVet has been updated with resources for Pain Management

The Comprehensive Addition and Recovery Act (CARA), signed into law in July 2016, is a comprehensive effort to address the opioid addiction epidemic. In accordance with CARA, VHA is reducing reliance on opioid medication for chronic pain management, providing safer prescribing and monitoring practices, and moving towards a Veteran-centric, biopsychosocial care plan. CARA expands the comprehensive approach to Veteran care with enhanced patient and community interactions by improving access to the state prescription drug monitoring programs, requiring VA to conduct community meetings, and expanding the VA Patient Advocacy Program. VHA is expanding its efforts in complementary and integrative health treatments through the development and execution of a strategic plan to expand complementary health, the execution of pilots in each VISN, and supporting an independent commission to provide additional recommendations. VHA is conducting reviews of the credentialing process

during on-boarding and off-boarding of clinicians. These reviews explore potential risk areas related to any license violations which may impact their fitness for duty. CARA implementation continues to gain momentum through internal and external communications, program expansions, and education focusing on the health and safety of Veterans under our care.

Question: Modernizing and Consolidation Efforts:

In your testimony you made mention of consolidation care. Can you please explain what is meant by consolidation of care, if this is closing down facilities and clinics or is this streamlining efforts to increase access to care and make things easier for veterans?

VA Answer: VA needs a different approach to purchasing care in the community to ensure that we can fully care for Veterans. We need your help in modernizing and consolidating community care. We believe that a redesigned community care program will not only improve access and provider greater convenience for Veterans, but will also transform how VA delivers care within our facilities. VA is finalizing its plans for a successor to the Choice program and looks forward to engaging with Congress in the months ahead.

The Veterans Choice Program was a bridge to give VA time to address deficiencies with its community car authorities, and to work with Congress to create a single consolidated community care program that would meet the needs of Veterans. VA's current community care authorities have disparate eligibility criteria and are confusing for Veterans, providers, and VA employees. We need a consolidated program in order to offer Veterans the access to care they deserve. VA community care must be easy to understand, simple to administer, and meets the needs of Veterans and their families.

This redesigned program must have several key elements. First, we need to move from a system where eligibility for community care is based on wait times and geography to one focused on clinical need and quality of care. This will give Veterans real choice in getting the care they need and ensure it is of the highest quality. At a minimum, where VA does not offer a service, Veterans will have the choice to receive care in their communities. Second, we need to make it easier for Veterans to access urgent care when they need it. This will ensure that Veterans will always have a choice and pathway to get their urgent needs addressed. Third, the new program must maintain a high performing integrated network that includes VA, Federal partners, academic affiliates, and community providers. We need to ensure that VA is partnering with the best providers across the country to take care of our nation's Veterans. Fourth, it must assist in coordination of care for Veterans served by multiple providers. Finally, we must apply industry standards for quality, patient satisfaction, payment models, health care outcomes, and exchange of health information. By doing so, Veterans can make informed decisions about their care and VA can have the tools to better compete within communities.

We believe redesigning community care will result in a strong VA that can meet the special needs of our Veteran population. Where VA excels, we want to make sure that the tools exist to continue performing well in those areas. Veterans need the VA and for that reason, community care access must be guided by principles based on clinical need and quality. VA needs the

support of Congress to level the playing field with industry by making it easier to modernize our infrastructure, leverage IT technologies, hire the best talent, and operate more like the private sector.

[Questions for the Record submitted by Congresswoman Wasserman Schultz for The Honorable David J. Shulkin follows:]

CHOICE PROGRAM VS. COMMUNITY CARE & SKINNY BUDGET

Question: The FY 2018 request included $3.5 billion for the Choice Program. This program was recently extended past the August expiration date so the remaining funds could be used. Why is the Administration requesting the additional $3.5 billion?

VA Answer: At the time of the FY 2018 Budget, the Administration was still evaluating the future of the Choice Program, including its potential successor. The Budget requests $3.5 billion in new mandatory budget authority to continue the Choice Program in FY 2018 while we work towards the successor program. There was no Choice Program funding requested in VA's FY 2018 Advanced Appropriation.

Question: It has been reported you're your "Choice 2.0" plan would include the elimination of the wait time and distance rules in the current program, along with new procedures for scheduling appointments and repaying private-sector physicians. Is this revamp needed because of the additional funding for Choice in FY 2018?

VA Answer: The VA successor plan for the current Veterans Choice program has not been finalized. The funding in FY18 will provide a bridge to use the existing programs while we work towards the new consolidated program

Question: At face value adding more money for the Choice Program looks like a good idea. However, when you factor in that in the FY 2017, Milcon/VA bill created the Medical Community Care account and provided $7.2 billion in FY 2017 and $9.4 billion in FY 2018 to consolidate all community care programs under a single appropriation wouldn't adding more money for Choice be redundant?

VA Answer: No, the FY 2018 Budget's request for Medical Community Care and Choice Program appropriations reflects the total estimated need for all community care.

Question: It was my understanding that Choice was a bridge for VA to transition to Community Care, is that not the case and can you explain the differences between the two? What is the better option for our Veterans, Choice 2.0 or Community Care?

VA Answer: Choice was a bridge to give VA time to address deficiencies with its community care authorities, and to work with Congress to create a single consolidated community care program that would meet the needs of Veterans. VA's current community care authorities have disparate eligibility criteria and are confusing for Veterans, providers, and VA employees. We

need a consolidated program in order to offer Veterans the access to care they deserve. We continue to work with stakeholders to finalize proposed legislation that will make sure VA community care is easy to understand, simple to administer, and meets the needs of Veterans and their families.

ELECTRONIC HEALTH RECORDS (EHR)

Question: The Secretary is currently assessing whether VA will stay with its VistA electronic health record system and will make a decision by July 1, 2017. Is one of his goals to get VA out of the software development business?

VA Answer: VA is moving toward an environment where software development is done outside VA. VA continues to work closely with Industry and the Department of Defense (DoD) to standardize terminology and data, which is the foundation for interoperability, regardless of the brand of software, or type of system either agency utilizes. Data terminology and standards are the center of gravity for the Committee's stated goal and VA and DoD's requirement for interoperable patient information.

As new medical tests, medical technology, and clinical terms are added to the lexicon of American healthcare, data standards and terminology will need to be updated. VA, its Community Care Providers, and DoD will always face a requirement to maintain up-to-date registries and data terminology and standards to ensure this interoperability continues.

VA is committed to a buy first approach in its Strategic Sourcing function, which includes VA's approach to software acquisition. This approach ensures that existing best-in-class technology solutions are purchased whenever possible, rather than being developed and maintained by VA. In short, it is VA Office of Information & Technology's (OI&T) view that development should only occur once market research is done to show no commercial solution, to include commercial off-the-shelf (COTS) software, is available. OI&T is committed to maximizing the use of commercially available software including those used by DoD and the private sector. As it relates to the modernization of our electronic health record, VistA, the Secretary announced on June 5th that VA will move toward a single common system by adopting the EHR system that is being deployed by DoD, which at its core consists of Cerner Millennium.

The adoption of the same system between VA and DoD will allow for all patient data to reside in a common system, so there will be a seamless link between the departments without the manual or electronic exchange of information. A Veteran will now be able to have a single common system from the time of enlistment, commission, or graduation from one of our nation's military academies throughout their life, with one single lifetime record.

Question: In addition to EHR, how many other software programs is the VA working on and how many of those have commercial options?

VA Answer: VA has a total of 317 projects currently underway, which serve 155 systems. These projects relate to the entire mission set of VA in Health, Benefits and Memorials. COTs solutions will increase speed of access to VA and Veterans, and allow VA to concentrate resources on core

mission sets. Many of these programs relate to legacy solutions that with investments in state of the art COTS solutions will alleviate the need for these projects. Currently, VA does not maintain aggregated information regarding commercial options that would meet business owner requirements for all 155 systems currently under development. During the planning process for individual programs, projects and activities, the former Chief Information Officer (CIO) issued guidance requiring investigation of commercial options prior to initiating a new start development project.

Question: How much money could the VA save if it relied more on the private sector for its software needs?

VA Answer: VA does not maintain aggregated information regarding commercial options that would meet business owner requirements for all 155 systems currently under development. The move to COTS solutions enables VA to take advantage of changes in IT solutions instantaneously. It also allows VA to enter into contract negotiations that will influence new technologies. VA does not have on record life cycle pricing information from the private sector for software systems that would meet all business owner requirements at VA. VA is committed to responsible stewardship of taxpayer dollars, and carefully evaluates options for software modernization prior to initiating any development or procurement activity.

Question: As Secretary Shulkin goes through your EHR review, have you taken a look at the process DOD went through when they were picking a new EHR system?

VA Answer: VA has carefully observed DoD's experience and lessons learned from the EHR acquisition at DoD. VA continues to be grateful for the time and expertise DoD personnel have shared during this time of transition, in an environment of competing priorities for their time.

In addition, DoD has made available a library of documents that capture their evaluation, and decision making process, which VA has taken into consideration. Formally, VA has official communications, and program activity regarding EHR interoperability with DoD through the Interagency Program Office

Question: This subcommittee tried to get VA and DOD to use the same system, in fact under Chairman Culberson and Ranking Member Bishop language was included to force VA and DOD to pick one system. This language did not say what system but only that it should be one system. It was a battle that they lost, but were they on the right track and do you believe it should have been a joint venture between the two departments?

VA Answer: VA must have a longitudinal EHR that will assist VA in improving the Veteran experience, improve employee experience, and facilitate continuous performance improvement. VA will ensure the EHR solution will be fully interoperable with our partners in Community Care that VA partners with under the Veteran Choice Program and DoD; finally the EHR system will integrate with the VA IT environment, and serve the Department well into the future.

VA continues to be grateful for the Committee's strong interest and continued involvement in the effort to provide our Veterans and active duty personnel optimized, longitudinal, interoperable EHRs.

VA has used Committee recommendations, and the expressed goals of Congress to guide and inform improvements to the current system, and requirements for any future system.

Question: Realistically how far away is VA from having a new EHR system and how much do you think it will cost?

VA Answer: On June 5, 2017, Secretary Shulkin announced that VA is authorized, through the signing of the public interest Determination and Findings, to negotiate directly with Cerner to acquire a commercial solution to replace the existing VA EHR.

The acquisition of VA's new Electronic Health Record will mirror DoD in the time from acquisition to full deployed capability. However, at this time, VA is unable to estimate a timeline for a plan of actions and milestones. As negotiations progress over the coming months, VA looks forward to following up with the Committee regarding cost estimates, system capabilities, and estimated timelines.

VA STAFFING

Question: Can you explain how the hiring freeze in place for some senior positions works and how many positions fall under this new guidance and how do you think this will streamline the VA?

VA Answer: Currently the hiring freeze for senior positions is primarily limited to those within headquarters organizations, not at field facilities where there may only be one executive position. VA is actively evaluating options to improve efficiency, effectiveness and accountability. As we identify areas where we may be able to streamline, eliminate, restructure or merge activities, we are also evaluating impacts to overall workforce requirements.

Question: Is there any concern that leaving these positions vacant will have an effect on Veterans services or further scare away qualified personal?

VA Answer: Not at this time. As mentioned in the response to question #1, the hiring freeze for senior positions is primarily limited to those within headquarters organizations, not at field facilities. The VA will continue to prioritize and fill vacancies as necessary to meet mission requirements and we believe quality candidates will continue to apply for these positions.

Question: All Senate-confirmable positions remain unfilled by Trump Administration. Has the administration identified anybody for these positions can you provide a timeline for each vacant position?

VA Answer: The commission has convened for the Under Secretary for Health and the Under Secretary for Benefits positions. A nominee is moving forward for the Chairman of the Board of Veterans' Appeals. Interviews continue for the Assistant Secretary for Information Technology. We are working diligently to fill these positions.

Question: The positions for the Under Secretary for Health, the Assistant Secretary for Information & Technology, and the Chairman of Board of Veterans Appeals all remain empty. How will this affect VA's efforts on fixing the Choice Program, selecting an EHR, and reforming the Board of Appeals? Don't you believe these individuals should be in place before these changes begin? Are you having problems identifying people for these jobs?

VA Answer: The VA has career executives in each of the respective organizations who would otherwise be very instrumental in implementing these efforts; they will continue the forward progress until there is a political appointee onboard. Secretary Shulkin considers filling these positions a top priority. The commission has convened for the Under Secretary for Health and the Under Secretary for Benefits positions. A nominee is moving forward for the Chairman of the Board of Veterans' Appeals. Interviews continue for the Assistant Secretary for Information Technology. We are working diligently to fill these positions.

FEMALE VETERANS

Question: As we've acknowledged the ability for our veterans to receive various medical services at a VA center greatly increases the likelihood our veterans are receiving the care they need. With that in mind and with the growing population of women veterans, I'd like to know what portion of care for our women veterans is provided in the VA versus in the community? Is there a difference in wait times between women and male veterans?

VA Answer: Approximately, 463,662 female Veterans completed 7,503,811 appointments through VA Care in FY16. An estimated 73.9 percent were provided in house, while 26.1 percent were provided through community care. At the national level, there were no significant differences in wait times for women versus men Veterans.

Question: During the subcommittee's recent visit to the DC VA Center as well as during my most recent visit to my local VA center in Miami, I've had the chance to tour the women's clinic. Both were exceptional facilities, and I wanted to know, what is the VA doing to set up separate spaces, within the larger medical building, where women veterans have their women-oriented appointments?

VA Answer: VA has also focused on improving its facilities to meet the needs of the growing numbers of women Veterans we serve. VHA has adopted Environment of Care (EoC) standards to review and assess such factors as facility privacy and security as they relate to care for women Veterans. These standards are now incorporated into a tablet-based EoC survey that is conducted regularly. The facility Women Veteran Program

Manager is a member of the EoC team. The EoC data is shared with the facility and the Veterans Integrated Service Network (VISN) monthly, and is the responsibility of the VISN Capital Asset Manager.

When there is a need for remodeling or construction to enhance the facilities, the project is either prioritized at the VISN level or submitted through the Strategic Capital Improvement Process (SCIP), depending on whether the project is pure renovation or adds new space. All projects are prioritized. Projects that include the needs of women Veterans are given an additional scoring bonus in the prioritization. The Office of Women's Health Services in VHA is a member of the review team for the SCIP review process and provides input on the specific facility needs for accommodations for women Veterans as set forth in the initial guidance and prioritization.

VA has enhanced the provision of care to women Veterans through Designated Women's Health Primary Care Providers (WH-PCP). By end of fiscal year 2016, VA had trained over 3,000 women's health providers. VA has at least one WH-PCP at all of VA's health care systems. In addition, 90 percent of Community-Based Outpatient Clinics (CBOCs) had a WH-PCP in place. VA is training additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a WH-PCP.

Question: Is the plan there a plan to include these type of spaces in all VA Medical Facilities?

VA Answer: VA has also focused on improving its facilities to meet the needs of the growing numbers of women Veterans we serve. VHA has adopted Environment of Care (EoC) standards to review and assess such factors as facility privacy and security as they relate to care for women Veterans. These standards are now incorporated into a tablet-based EoC survey that is conducted regularly. The facility Women Veteran Program Manager is a member of the EoC team. The EoC data is shared with the facility and the Veterans Integrated Service Network (VISN) monthly, and is the responsibility of the VISN Capital Asset Manager.

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that every woman Veteran has the opportunity to receive her primary care from a WH-PCP.

Question: In this Committee's Military Quality of Life hearing in March, we met with the branches of the military in the aftermath of the Marines United scandal where servicemembers posted nude photos of women servicemembers. Given that some of the victims are now veterans and no longer active-duty, what is the VA doing to provide them with the necessary care and support? Can you speak to the VA's efforts with regard to Military Sexual Trauma (MST) and how you let Veterans know this service is available?

VA Answer: VA provides free counseling and treatment for mental and physical health conditions related to MST. VA has implemented a number of outreach and awareness-raising initiatives to help Veterans and Servicemembers become aware of MST-related services available to them through VA, and to ensure that VA and DoD staff have the information they need to help survivors access this care. For example, MST-specific information is now included in the Transition Assistance Program completed by all Servicemembers leaving active duty, as well as in the Separation Health Assessments VA conducts with Servicemembers who file disability claims. VA's national MST Support Team also engages in conversations with DoD's Sexual Assault Prevention and Response Office (SAPRO) and each of the individual Services' Sexual Assault Prevention and Response (SAPR) programs about how to best reach Servicemembers transitioning from military service, as well as newly discharged Veterans. Since becoming aware of the Marines United scandal, VA has reached out to various offices within DoD to remind them of the availability of MST-related services through VA.

Every VA health care system has one or more MST Coordinators who, among their duties, serve as advocates and sources of information for Veteran MST survivors and facilitate access to needed health services. Throughout the year, MST Coordinators engage in local outreach efforts to raise awareness about the availability of MST-related services. Because the ability to reach a MST Coordinator can often be critical to accessing MST-related services, VA conducts a biannual "Answer the Call" campaign, where "secret shopper" test calls are made to VA medical centers and VA community-based outpatient clinics in order to verify frontline staff, such as telephone operators and clinic clerks, are familiar with the terms "military sexual trauma" and "MST," readily able to identify and direct callers to the MST Coordinator, and sensitive to Veterans' privacy concerns.

VA has also developed and disseminated a number of outreach posters, handouts, and educational documents, and ensured inclusion of information about MST on relevant va.gov websites. For example, MST is featured in the VA award-winning "Make the Connection" (www.maketheconnection.net) website, which features videos of Veterans telling their stories of recovery and provides information about MST and VA MST-related services. VA also has developed an MST-specific website (www.mentalhealth.va.gov/msthome.asp) with information about difficulties commonly associated with MST, available VA care, MST-related disability compensation, and how to learn more about these issues.

Question: With female veterans committing suicide at six times the rate of female civilians, what is the VA doing to identify and implement strategies that address the unique mental health needs of our women veterans?

VA Answer: VA notes that after adjusting for age differences, the rate of suicide among female Veterans in 2014 was 2.5 times greater than that for women in the civilian US adult population. VA is leading national efforts to understand suicide risk factors, develop evidence-based interventions strategies, and proactively identify and care for Veterans who are in crisis or at risk for suicide. VA conducts comprehensive evaluations of suicide deaths among Veterans, including gender differences in suicide rates and risk factors. VA is committed to ensuring that appropriate services are available to meet the treatment needs of women Veterans who may be at risk for suicide. For example, evidence-based therapies for posttraumatic stress disorder (PTSD), including prolonged exposure and cognitive processing therapy, have been shown to decrease suicidal ideation. These treatments are available at every VA medical center.

VA has numerous suicide prevention resources available, including a 24-hour per day Veterans Crisis hotline (1-800-273-8255), 24-hour Veterans Crisis Online Chat (http://www.Veteranscrisisline.net/ChatTermsOfService.aspx), as well as a suicide prevention-focused website with numerous resources for Veterans and their families (http://www.mentalhealth.va.gov/suicide_prevention/). Every VA medical center and large community-based outpatient clinic has a Suicide Prevention Coordinator, who serves as a local point of contact and is responsible for tracking appointments and coordinating enhanced care between Veterans and providers.

More broadly, VA provides a full continuum of mental health services for women Veterans, including general outpatient, specialty, inpatient and residential rehabilitation treatment options. Outpatient services include mental health assessment, evaluation, pharmacotherapy, and individual, group and family psychotherapy. Some specialty care programs that target problems such as PTSD, substance use, depression, homelessness, and military sexual trauma (MST) — each of which has been associated heightened suicide risk — include women-only services (e.g., women-only groups). Many facilities provide this care through specialized women-only outpatient treatment teams. For Veterans who need more intensive treatment and support, VA has residential programs that provide treatment to women only, or that have separate tracks for men and women. These programs are considered regional and/or national resources, not just a resource for the local facility. Mixed-gender options are also available. VA also has inpatient programs for acute care needs, such as psychiatric emergencies and stabilization, or medication adjustment. More than half of VA mental health providers are female, and national policy strongly encourages all VA health care facilities to offer Veterans the choice of a provider of a particular sex for MST-related treatment whenever possible, and to offer all Veterans consultation with a same-gender provider for gender-specific concerns.

VA has enacted universal screening programs for common mental health conditions and related experiences — including those associated with increased risk for suicide — such as depression, PTSD, alcohol use, and MST. These screening programs provide an opportunity to identify individuals in need of mental health care and refer them to appropriate mental health services. Screening rates are very high, exceed private sector rates, and do not significantly differ by gender.

Strong clinical training initiatives are in place to ensure that mental health providers have the knowledge and skills to meet the unique treatment needs of the growing population of women

Veterans. These include online resources, didactic teleconferences about issues specific to women's mental health — including a special series for mental health prescribers — expert clinical consultation, and interactive web-based trainings that use videoconferencing to facilitate psychotherapy demonstrations and role-playing between instructors and trainees. In addition, the first National Women's Mental Health Mini Residency was held in 2016. Approximately 200 participants representing nearly every VA medical facility nationally, as well as Vet Centers, attended this intensive, three-day training event. Nationally recognized experts led interactive sessions in a broad range of topics related to the treatment of women Veterans, including evidence-based psychotherapies and psychiatric medications. Specific training topics included treating women who have experienced gender-linked traumas, such as intimate partner violence and sexual abuse, working with women whose mental health problems are influenced by hormonal changes and the reproductive cycle, and understanding suicide risks in women Veterans. As part of this training, each participant developed an Action Plan to improve women's mental health delivery at their local facility. Each participant also now serves as a member of a national network of Women's Mental Health Champions, with a shared commitment to advancing gender-sensitive mental health services for women Veterans.

VETERANS CRISIS LINE (VCL)

Question: Mr. Secretary, before our hearing with the inspector general last month, there were reports of serious issues at the veterans erisis line regarding training and the number of calls that were being forwarded to backup centers. Within days of the IG's report, the VA said the issue had been "fixed." Can you explain how you "fixed" it and what are you are doing to ensure our veterans are receiving the response they need and are not falling through the cracks? What changes have been made since this report?

VA Answer: Action plans have been developed to address all of the recommendations for the March 2017 Report. We began implementing the action plan in May and expect be completed by December 2017. These actions include:

- Incorporating a new Customer Relationship Management (CRM) system so caller information is automatically populated with the phone number of the caller.
- Evaluating policies and procedures related to VCL call recordings, and ensuring all staff are educated on policies, to include roles and responsibilities.
- Developing and implementing a training plan for educating staff on the use of call recordings and how to walk a caller through any concerns regarding the recording of calls.
- Establishing a governance structure to ensure cooperation and collaboration between program offices and appropriate responsibility for clinical and administrative functions.
- Developing clear guidelines for clinical and administrative decision-making. These guidelines will focus on ensuring Veterans who call receive high-quality care based on clinical judgement and operations are managed with sound business practices.

- Collaborating with other VA program offices to provide training to VCL management staff in core competencies of safe and high quality leadership.
- Adding to VCL Executive Leadership Council's (ELC) responsibilities. VCL ELC is the governance structure responsible for documenting, tracking, and directing action on clinical quality performance measures.
- Implementing root cause analysis and corrective action plans to ensure opportunities for improvement are appropriately implemented.

Question: There seems to be some confusion regarding training for mental health services at VA. Can you please explain the training that local call centers receive and what training VCL staff receives?

VA Answer: All VA employees receive "Operation SAVE" training, a basic gatekeeper training on suicide prevention for any VA employee, regardless of background and experience in suicide prevention.

VCL responders also receive training in the components of Operation SAVE. In addition to this, responders receive a comprehensive, population specific and crisis intervention focused training and quality assurance program. The four-tier VCL training approach includes:

- Tier 1: Classroom training, including a minimum of 81.5 hours of classroom training and final knowledge checks.
- Tier 2: Precepting/on the job training, with Responders listening to live calls as well as taking calls with the support of a preceptor.
- Tier 3: Supervisor verification, where a Supervisor listens to/monitors live calls answered by the trainee.
- Tier 4: Ongoing Silent Monitoring for Quality Assurance to evaluate, coach, and continually improve service.

CLAIMS BACKLOG

Question: There are a little under 100,000 remaining and that number is starting to tick back up. I know that you have suspended mandatory overtime which has led to this increase. My questions are do you have enough claims processors to keep the backlog from spiraling out of control?

VA Answer: Yes, VBA believes that we have the proper authority to hire the needed amount of employees to process claims. VBA greatly appreciates the investments made by the President and Congress over the past several years to include support for 2017 request which included 300 additional full time employees (FTE). These additional FTE will be focused on completing non-rating claims as we work to improve timeliness.

Question: The break out for the claims backlog is a mixture of those applying for initial claims and those applying for supplemental claims. How does the VA prioritize those claims and will the VA ever get to a functional zero regarding the claims backlog?

VA Answer: While VBA makes every effort to work claims in a timely manner, we recognize that some pending claims require prolonged processing to ensure VA meets its legal obligations to assist Veterans in the development of their claims. Complex claims (involving multiple body systems or a high number of claimed contentions) do tend to take longer as VA considers additional evidence and/or new medical conditions throughout the claims process. Additionally, late evidence or new contentions stop the momentum made in processing the claim, since they usually require a new round of evidence-gathering, medical examinations, and analysis, thus prolonging the determination of a decision. VBA does not currently differentiate between initial and supplemental rating claims, nor do we differentiate between simple and complex rating claims; however, VBA prioritizes certain rating claims – our oldest claims, fully developed claims, and special interest claims (homeless, extreme financial hardship, former prisoners of war, terminally ill, etc.). Based on claim characteristics that make a claim more complex as well as VA's responsibility to help Veterans develop their claims, VA expects some claims to take longer than 125 days. One of VBA's published strategic targets is to reduce the disability rating claims backlog to less than 10 percent of the total rating inventory by FY 2021.

EXCESS INFRASTRUCTURE

Question: It has been reported that the Secretary of Veterans Affairs is seeking to close more than 1,100 VA facilities nationwide as it develops plans to allow more veterans to receive medical care in the private sector. Will this be legislative proposal or does the VA have existing authorities to close these facilities?

VA Answer: VA has identified 1,214 vacant and/or underutilized buildings that are geographically dispersed at VA campuses nationwide. These are individual buildings, and do not reflect entire facilities at any given location. Disposal or reuse of any of vacant buildings does not mean that the VA system will be privatized nor change the services or functions that would impact Veterans. The intent is to identify better ways for VA to utilize its real estate to provide care and access for Veterans.

VA does not require legislation to divest of vacant and/or underutilized buildings, but must follow applicable laws when doing so.

Question: Does the VA plan to use a "BRAC" style commission to decide what facilities will be closed?

VA Answer: No, a "BRAC" style commission is not needed for these buildings that are already vacant.

For VA's broader capital infrastructure portfolio, we will work with the Administration and Congress to develop a National Realignment Strategy to look at every facility to make sure it's being utilized appropriately and ensure current resources are being used in the most effective manner.

Question: According to the Associated Press, the buildings VA was reviewing for possible closure would cost millions of dollars to replace. It noted that about 57 percent of all VA facilities were more than 50 years old. Of the 431 VA buildings it said were vacant, most were built 90 or more years ago, according to agency data. Can you provide the subcommittee with a list of these facilities by age?

VA Answer: A list of VA's vacant and underutilized buildings is attached. The list includes the year the facility was built and the building's historical status. The buildings have been sorted by age, with the oldest at the top. The oldest vacant building dates back to 1869.

[Questions for the Record submitted by Congresswoman Wasserman Schultz for The Honorable David J. Shulkin follows:]

Billing & Collections

Question: Mr. Secretary, third party billings and collections problem are especially important given comments made during today's hearing. In response to several Members, you mentioned that the VA is not doing a good job of paying outside health care providers, there remain issues with the electronic claims process that you hope to address in Choice 2.0, and that the VA needs to modernize its systems and to bring in best practices from the private sector. However, the VA also has challenges in collecting payments from private sector care providers.

In that regard, what is the VA doing today to utilize best practices from the private sector to improve its collections from third parties?

VA Answer: VHA has partnered with industry experts to help instill best practices into its third party collection process. By way of the Revenue Transformation effort, six portfolio teams are aligned around key components of the revenue cycle (e.g., registration, clinical documentation, coding). Both industry and VA subject-matter experts are embedded within each of these teams. As VHA develops new processes, they remain informed of private sector best practices from experienced revenue cycle consultants. Additionally VHA is identifying internal best practices taken from across its entire enterprise to leverage for new recommendations and process standardizations.

PTSD Treatment and Collaboration with the Private Sector

Question: The private sector is making advances in innovative medical and pharmacological treatments for Post-traumatic Stress Disorder (PTSD) that address unmet need, but too few promising treatments are currently in development. We need to encourage more shots on goal. We need to reduce barriers to development, including: difficulty accessing VA datasets on PTSD; limitations on the ability of Veterans to participate in clinical trials; and a lack of timely response from VA providers when participating in research with private-sector entities. **Has the VA prepared a plan for how it can best cooperate with the private sector to promote R&D of new PTSD medical therapies? If not, can you prepare one within the next 90 days?**

VA Answer: Yes. Clinical Science Research and Development (CSR&D) currently has 53 ongoing awards in PTSD with current year expenditures of approximately $10 million. VA is a long-standing leader in advancing knowledge of and treatments for PTSD in Veterans. While our research program has been particularly strong in establishing the evidence base for pharmacologic and psychosocial therapeutic treatments for PTSD, we recognize a critical need for delivery of more effective medications. VA is often dependent upon industry that develops and possesses the new medications for disease since VA does not have that capability.

In June 2016, a panel of VA scientific experts convened by CSR&D to assess the overall research portfolio for PTSD medications. The panel determined that there was a lack of work towards identifying, testing and confirming the most effective PTSD medications for our Veteran population. In September 2016, CSR&D hosted an Industry Day to describe the various ways VA and industry could work together. As an outcome, VA ORD has partnered with two companies (Tonix and Corcept) to conduct clinical trials in PTSD.

In December 2016, CSR&D announced the PTSD Psychopharmacology Initiative (PPI) to foster studies across the clinical efficacy and effectiveness path. This initiative included the following elements: call for proposals; clinical trials; and VA medical centers to return site surveys to indicate capacity across the system to support these clinical PPI trials; and financial support for planning meetings related to approved study concepts.

CSR&D held a PPI training workshop (May 16-17, 2017) to train early-career/mid-level VA clinicians in conducting PTSD clinical trials in VA. Eighteen attendees from various VA medical centers received intense training from ten VA faculty personnel who are experienced in the conduct of PTSD clinical trials in VA. In addition, faculty members assisted in development of the research proposals which will be submitted to VA for peer review for the September 2017 deadline. This effort will advance our progress towards new medications for PTSD. Recommendations have been put forth for improving trial methodologies and training requirements specifically to increase the likelihood of finding future treatments. A paper with these ideas was recently published in a peer-reviewed medical journal.

Question: The VA has made great strides in improving access to PTSD care and diagnostics, but still only about half of Veterans suffering from PTSD are seeking care according to an Institute of Medicine study. While expanding access to care more broadly, we specifically need more medical therapies for PTSD. Unfortunately, too few are in development. I have heard concerning reports that researchers and developers are having trouble accessing VA datasets and biological samples, and face significant delays when trying to work with VA sites on clinical trials. **Has the VA prepared a plan for how it can best facilitate R&D of new PTSD medical therapies? If not, can you prepare one within the next 90 days?**

VA Answer: ORD has undertaken a number of initiatives to reduce barriers to trials in general and PTSD in particular, whether funded by VA, other Federal funders or private industry. As described earlier, VA has a PSTD Psychopharmacology Initiative that involves partnerships with industry to increase and speed studies of promising medical therapies. At the same time our Central Institutional Review Board (CIRB) facilitates review of multi-site studies which are often required to recruit sufficient subjects. This has helped make the approval process for VA multi-site trials more efficient and we have recently expanded the CIRB capabilities for overseeing industry trials (three so far). In order to further expand this capacity, we need a model to pay for the increased CIRB workload and we are working with the National Association of Veterans' Research and Education Foundation on a mechanism that would allow industry to support those costs. We are unaware of specific cases in which researchers have requested access to datasets or samples in this area. However, there are requirements and policies in place for obtaining such items provided that informed consent and HIPAA authorizations permit such sharing. Our centralized data resource, VA Informatics and

Computing Infrastructure can now be used to identify sites with sufficient number of patients with PTSD that would be good for conducting research.

Question: The VA has an extensive patient population and facility network, but does not always provide the necessary support for clinical trials. One recent multi-center Phase 2 clinical trial in Veterans for a potential military PTSD medication sought to recruit participants from three VA facilities. Although the non-VA sites participated on schedule, the VA facilities were slow to secure the necessary approvals. One VA facility received approval only at the very end of the study, too late for meaningful participation, and another failed to obtain approval entirely. **Has the VA assessed how it can better support clinical trials? If not, can you commit to doing so within 90 days, with input from researchers and other interested stakeholders?**

VA Answer: VA cannot address the specific issues involving approval delays for the Phase 2 clinical trial without additional information regarding the trial, but VA has processes in place to ensure that research is conducted safely and in compliance with all regulatory requirements. As a Federal agency, VA has legal and contractual requirements that it must adhere to that academic medical centers and other non-VA sites may have more flexibility to address. In activities involving an industry collaborator, procedures need to consider that Veterans and the Federal Government obtain maximum benefit for any contributions to the research. VA must also confirm that it is capable of safely and fully conducting research within its facilities.

VA ORD understands regulatory, clinical, and operational requirements to support clinical trials. It has continually been evaluating and implementing ways to improve how trials have done for over a decade as industry trials have grown in their influence and scope in American medicine. Many challenges are not unique to VA and reflect the national clinical trials enterprise as a whole. However, VA also has the ability to provide training for future investigators to be leaders in these areas.

Question: From the outside, it seems that the VA is reluctant to engage in and support clinical trials for treatments targeted for Veterans. **Have you had the opportunity to observe how the Department responds to requests to participate in a clinical trial? Can you share with us your observations? What would you recommend the VA change?**

VA Answer: VA has been a part of a number of clinical trials for treatments targeted for Veterans. VA's history in conducting clinical trials for Veterans treatment dates back to the earliest multi-site clinical trials conducted in the United States in the 1940s. Since then, it has either supported or participated in a number of trials funded by Federal or private dollars. As noted previously, VA received approximately $45 million in FY 2016 [please see earlier comment from Question 10 Dent on this matter] from outside/industry funds to conduct clinical trials of new treatments. Furthermore, VA participates in the Clinical Trials Transformation Initiative, a public-private partnership that includes industry, FDA, Federal, academic and non-profit organizations to determine how to improve completion of clinical trials nationally.

How industry initiates a clinical trial in VA often varies depending on who or how an industry or outside partner has worked with and/or initially contacts. Challenges often arise when VA facilities are unfamiliar with requirements for conducting trials. In addition, these facilities do not have supporting mechanisms and experience working with industry. Similarly, industry may not understand that each VA facility by statute [is this policy or statute; if statute please cite] has individual oversight (local Research and Development Committee and Institutional Review Board) requirements. Therefore, for multi-site trials, VA sites must be approached individually if there is not a coordinating body. VA continues to work with its internal and external partners on ways to improve the clinical trials process while considering how to best serve the interests of Veterans.

Animal Welfare

Question: My colleagues and I have heard reports about the abuse of dogs and related transparency and accountability issues at several VA facilities. In one instance, these abuses were characterized by a VA oversight staffer as "reckless behavior" and "actions [that] threaten the integrity of [the] institution." Are you aware of these concerns, and what are you and your staff doing to investigate and correct these problems?

VA Answer: Yes, VA's Office of Research and Development (ORD) and the VA Chief Veterinary Medical Officer (CVMO) are aware of these concerns, the circumstances, the investigation of the local Institutional Animal Care and Use Committee (IACUC), and the corrective actions that the IACUC has since taken. All of this information was self-reported to the CVMO and to the NIH Office of Laboratory Animal Welfare by the facility, demonstrating the transparency and accountability that VA requires.

The specific comments quoted are those of a single member of the IACUC. The opinion expressed was not shared by the majority of the IACUC members, and the committee's decision was ultimately not to characterize the events according to this opinion. It is important to note that the comments were nevertheless included in the self-report, as required by VA policy, specifically to make it clear that there is no suppression of minority opinions. This is in keeping with VA policy to respect and seriously consider the perspective of each member of the IACUC. The VA Office of the CVMO has reviewed the response of the facility and found that it acted promptly, thoroughly, and responsibly. We and the facility continue to monitor this matter closely, and have observed no further problems with this important research since the corrective actions were put into effect.

Allegations of "abuse" are under investigation. The results of these investigations are not yet available; however preliminary information demonstrates that some of the accusations are based on false documents statements, and misrepresentations of facts.

At the request of the VA Office of the Inspector General (OIG), the VA Office of Research Oversight (ORO) has completed its investigation of the recordkeeping violations and allegations of animal abuse in the animal research program at the Richmond VA Medical Center (Hunter Holmes McGuire VA Medical Center, HHMVAMC). On 6/19/17, Four Corners professional staff members were briefed on ORO's 5/30/17 report findings by the Executive Director of ORO,

Dr. Doug Bannerman. Follow-up briefings to the personal staff members of other interested members of Congress were provided on 6/27/17 by Dr. Michael Fallon, the Chief Veterinary Medical Officer of the VA Office of Research and Development.

ORO's findings substantiated that the care of the animals was consistent with HHMVAMC self-report, and that the inadequacies had been corrected before the allegations were submitted to OIG. Other allegations, regarding failures to report according to regulatory requirements were found to be unsubstantiated, and were in one case based on a falsified document that was submitted with the complaint to OIG.

Because of VA's commitment to accountability, ORO did not limit its investigation to the specific items included in the complaint to OIG, but reviewed the entire animal research program at HHMVAMC. The additional deficiencies that ORO identified have all been addressed to ORO's satisfaction, and ORO has closed each of the concerns that were described in its report. It is important to note that these deficiencies largely involved failure to document proper care, and none were evidence of inadequate care. ORO did not find any evidence that these additional deficiencies reflected any negligence, incompetence, recklessness, or intentional misrepresentation.

Because of VA's policy of transparency and accountability, when errors occurred at HHMVAMC, the station promptly reported both the problems and the corrective actions that were taken to safeguard the welfare of the animals involved and to prevent recurrence. These reports showing VA accountability are available to the public through the Freedom of Information Act mechanism, but were used as the basis of the allegations of misconduct and lack of transparency.

Overall the findings reported by ORO, and VA's responses to them, are very much in keeping with VA's ongoing commitment to supporting the responsible animal research that is needed, which requires making sure that the animals are treated humanely and with respect. VA animal research has improved the lives of many millions, including millions of Veterans, and VA is dedicated to continuing to do the high quality research that is vital to improving health care for millions more.

Mammography Policy

Question: Mr. Secretary, during my visit to the DC VA Medical Center, I learned that the VA provides mammography coverage in accordance with the USPSTF guidelines- which recommends annual screening only for women over 50. In 2015, legislation was enacted that put a moratorium on insurance providers following these guidelines until there was consensus in the medical community, but the law did not apply to the VA. I'm currently working on legislation that would allow women veterans to receive the same coverage as women currently are in the private insurance market. **Is this legislation you would be open to supporting?**

VA Answer: VA cannot comment on proposed or pending legislation outside of the Administration's formal clearance process; however, we welcome the opportunity to provide official views on your draft or introduced bill, or to provide technical assistance upon request.

We would like to point out, however, that effective May 9, 2017, VA adopted, as a matter of clinical policy, the American Cancer Society's breast cancer screening guidelines, which give women a choice to begin screening at age 40. The guidelines also recommend starting yearly mammograms by age 45 and then every other year from age 55. The guidelines apply to women at average risk for breast cancer and complement VA's already-extensive program for breast care for Veterans.

Colorectal Cancer Screenings

Question: In screening for colorectal cancer, the VA has promoted the use of very inexpensive blood tests that have inferior results to either newer tests that have superior results or the gold standard of the colonoscopy, which is even more expensive.

These inferior bloods tests require their repetition annually and people are often reluctant to take the same test year after year if they are told the result is simply no evidence of cancer.

Recently HEDIS, which provides quality measures that have been adopted by 90% of the nation's health plans, added several new tests. Those tests have been adopted by Tricare including Tricare for Life. With many servicemembers leave the military before retirement and transfer to VA, there is a serious need to provide a continuum of care especially for a deadly cancer like colorectal cancer, which takes 50,000 American lives annually. Is there a reason for the lack of parity in providing what Tricare provides active-duty servicemembers? Does the VA have a plan for implementing these necessary and superior screening standards?

VA Answer: A VA panel of subject matter experts on health promotion and disease prevention recently evaluated the evidence on colorectal cancer screening and issued updated guidance for VHA, taking into account the 2016 recommendations of the United States Preventive Services Task Force (USPSTF). VHA's colorectal cancer screening guidance is as follows: "VHA recommends the following 4 screening modalities based on the highest levels of evidence available: FDA approved guaiac-based (gFOBT); FDA approved fecal immunochemical testing (iFOBT/FIT); sigmoidoscopy; and colonoscopy. CT colonography may be used under certain clinical situations." VHA's guidance regarding colon cancer screening was developed by the VHA Preventive Medicine Field Advisory Committee (PMFAC) and is based on the USPSTF current recommendation (2016).

The PMFAC takes many factors into consideration when developing evidence-based guidance to ensure the best care and outcomes for Veterans enrolled in VA health care.

The VHA National Center for Health Promotion and Disease Prevention, in collaboration with the VA National Gastroenterology Program Office, promotes VHA's colorectal cancer screening guidance across all VA medical centers. Additionally, VHA's Colorectal Cancer Screening

Directive policy ensures cross-communication to all VA medical centers of VHA's colorectal cancer screening guidance.

VHA follows many of the HEDIS® measures and compares these with the very highest level of scientific evidence. While HEDIS has added FIT-DNA testing to the colorectal cancer screening measure, HEDIS maintained the other modalities listed in VHA guidance. As noted on the HEDIS internet page, "HEDIS® measures and specifications are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications".

VHA will continue to monitor and review emerging evidence regarding benefits and harms of various modalities of colon cancer screening as we continuously strive to provide the highest quality evidence-based care to Veterans. VHA's colorectal screening preventive services guideline also conveys VHA's open-minded approach in considering screening strategies as the scientific evidence rapidly evolves, and as the available evidence grows, recommendations may change.

It is important to note that the USPSTF stated that "[m]ultiple screening strategies are available to choose from, with different levels of evidence to support their effectiveness, as well as unique advantages and limitations…[although] there are no empirical data to suggest that any of the strategies provide a greater net benefit."

[Questions for the Record submitted by Congresswoman Lowey for The Honorable David J. Shulkin follows:]

I have significant concerns that the VA needs to adjust to the needs of all veterans, not only men. This Committee included strong language in the FY17 Military Construction and Veterans Affairs spending bill to direct the VA to better address the health needs of women.

Question: Mr. Secretary, how will the VA ensure that female veterans are receiving high-quality health care for non-service connected health care needs, such as maternity care and obstetrics?

VA Answer: VA provides full healthcare services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. VA either provides on-site or pays for community care for full gynecological care, including maternity care, and seven days of newborn care to all women Veterans. Basic gynecology care is provided on-site by Designated Women's Health Primary Care Providers and specialty gynecology care is provided at most medical centers. VA has established the maternity care coordinator (MCC) program at VA medical centers, who are responsible for staying in contact with women during their pregnancies to support and coordinate their care. By acting as a liaison between the Veteran, the non-VA provider, and the VA medical facility, the MCC ensures that services and communications between the non-VA maternity care providers and the VA system are facilitated to ensure seamless and high quality maternity care for women Veterans. In addition, VA recently released the Preconception Care and Caring4Women Veterans mobile apps. Both apps provide important guidance for VA and non-VA care team members in caring for and counseling women Veterans. Caring4Women Veterans is designed to increase care team members' awareness of, and access to, current information about the unique physical and mental health needs of women Veterans; while Preconception Care provides actionable information to integrate preconception care into primary care visits.

Question: According to VA reports, approximately 23% of female veterans reported sexual assault while in the military. Additionally, female veterans are six times more likely to commit suicide than women in the general population, and female veterans between the ages of 18-29 are twelve times more likely to commit suicide than their male counterparts.

Given these startling statistics, what should the VA do to better address the mental health needs of female veterans?

VA Answer: VA notes that overall suicide rates are elevated among Veterans as compared to non-Veteran adults. After adjusting for age differences, VA analyses indicate that the rate of suicide among female Veterans in 2014 was 2.5 times greater than that for non-Veteran women in the US adult population. The statement that the

female Veterans age 18-29 were 12 times more likely to die from suicide than their male counterparts is incorrect. They were less likely to die from suicide than like-aged male Veterans; the rate among male Veterans age 18-29 was 2.6 times that of female Veterans age 18-29. On the other hand, female Veterans were 6.5 times as likely to die from suicide than non-Veteran women age 18-29. These statistics aside, VA recognizes the importance of addressing suicide risks among female Veterans.

VA provides a full continuum of mental health services for women Veterans, including general outpatient, specialty, inpatient and residential rehabilitation treatment options. Outpatient services include mental health assessment, evaluation, pharmacotherapy, and individual, group and family psychotherapy. Some specialty care programs that target problems such as PTSD, substance use, depression, and homelessness — each of which has been associated with Military sexual trauma (MST) and heightened suicide risk — include women-only services (e.g., women-only groups). Many facilities provide this care through specialized women-only outpatient treatment teams. For Veterans who need more intensive treatment and support, VA has residential programs that provide treatment to women only, or that have separate tracks for men and women. These programs are considered regional and/or national resources, not just a resource for the local facility. Mixed-gender options are also available. VA also has inpatient programs for acute care needs, such as psychiatric emergencies and stabilization, or medication adjustment. More than half of VA mental health providers are female, and national policy strongly encourages all VA health care facilities to offer Veterans the choice of a provider of a particular sex for MST-related treatment whenever possible, and to offer all Veterans consultation with a same-gender provider for gender-specific concerns.

MST is the umbrella term used by VA to refer to a Veteran's experience of sexual assault or sexual harassment (as this term is defined in 38 U.S.C. 1720D(f)) that occurred while the Veteran was serving on active duty, active duty for training or inactive duty training. VA has treatment authority to provide counseling and care and services to help them overcome psychological trauma resulting from (related to) such experience.

Recognizing that many survivors of MST do not disclose their experiences unless asked directly, it is VA policy that all Veterans seen for health care be screened for MST. VA data show that about 1 in 4 women and 1 in 100 men report that they experienced MST, when screened by a VA healthcare provider. Veterans who screen positive for MST are offered a referral to VA mental health services, and VA provides needed counseling, care and services, as authorized by law, free of charge.

In addition to VA's MST screening program, VA has enacted universal screening programs for common mental health conditions and related experiences — including those associated with MST and risk for suicide — such as depression, PTSD, and alcohol use. These screening programs provide an opportunity to identify individuals in need of mental health care and to offer them referrals to appropriate mental health providers and services.

With regard to suicide prevention in women Veterans, VA is leading national efforts to understand suicide risk factors, develop evidence-based interventions strategies, and proactively identify and care for Veterans who are in crisis or at risk for suicide. VA conducts comprehensive evaluations of suicide deaths among Veterans, including gender differences in suicide rates and risk factors. VA is committed to ensuring that appropriate services are available to meet the treatment needs of women Veterans who may be at risk for suicide. For example, evidence-based therapies for posttraumatic stress disorder (PTSD), including prolonged exposure and cognitive processing therapy, have been shown to decrease suicidal ideation. These treatments are available at every VA medical center.

VA has numerous suicide prevention resources available, including a 24-hour per day Veterans Crisis hotline (1-800-273-8255), 24-hour Veterans Crisis Online Chat (http://www.Veteranscrisisline.net/ChatTermsOfService.aspx), as well as a suicide prevention-focused website with numerous resources for Veterans and their families (http://www.mentalhealth.va.gov/suicide_prevention/). Every VA medical center and large community-based outpatient clinic has a Suicide Prevention Coordinator, who serves as a local point of contact and is responsible for tracking appointments, and coordinating enhanced care between Veterans and providers.

In addition, strong clinical training initiatives are in place to ensure that mental health providers have the knowledge and skills to meet the unique treatment needs of the growing population of women Veterans. These include online resources, didactic teleconferences about issues specific to women's mental health — including a special series for mental health prescribers — expert clinical consultation, and interactive web-based trainings that use videoconferencing to facilitate psychotherapy demonstrations and role-playing between instructors and trainees. In addition, the first National Women's Mental Health Mini Residency was held in 2016. Approximately 200 participants representing nearly every VA medical facility nationally, as well as Vet Centers, attended this intensive, three-day training event. Nationally recognized experts led interactive sessions on a broad range of topics related to the treatment of women Veterans, including evidence-based psychotherapies and psychiatric medications. Specific training topics included treating women who have experienced gender-linked traumas, such as intimate partner violence and sexual abuse, working with women whose mental health problems are influenced by hormonal changes and the reproductive cycle, and understanding suicide risks in women Veterans. As part of this training, each participant developed an Action Plan to improve women's mental health delivery at their local facility. Each participant also now serves as a member of a national network of Women's Mental Health Champions, with a shared commitment to advancing gender-sensitive mental health services for women Veterans.

Question: What is the VA doing to address mental health issues that may emerge during the transition out of the military and into civilian life?

VA Answer: Women Veterans are the fastest growing group of VA health care users and are increasingly using VA mental health services. This is especially true for our

newest generation of Veterans. Although the majority transition smoothly to civilian life, some struggle. Reconnecting with family and friends, reintegrating into a civilian lifestyle, and resuming parenting, caregiver and professional roles can be stressful for these women Veterans and their families. As the female Veteran population continues to grow, VA aims to ensure that our delivery of care is sensitive to women Veterans' privacy and other needs, including the unique readjustment needs of those who have recently separated from military service.

Strong outreach efforts are critical to VA's efforts to engage our newest women Veterans, and VA and the Department of Defense (DoD) partner on a number of transition-related initiatives to ensure that Servicemembers leaving the military are aware of the VA benefits available to them. For example, as part of their mandatory out-processing during separation from the military, all Servicemembers participate in the Transition Assistance Program (TAP), which provides training on readiness for civilian life. A major component of TAP is an orientation to VA, including information on VA benefits, such as disability compensation and health care. Services described include care for problems that disproportionally affect women Veterans, such as the availability of free counseling and care for MST-related conditions. By preparing Servicemembers with information about their care and benefits options at a time when they are actively engaged in planning for their civilian life, TAP is a key component in VA/DoD outreach. As not all Servicemembers need or are interested in learning about VA health care or VA's health care enrollment process at the time they participate in TAP, it is also important that they be able to easily locate information about enrollment, VA health care services, and points of contact at a later time. VA ensures that up-to-date information about VA I health care, including mental health services, is available on key internet websites likely to be visited by Servicemembers and Veterans.

The VA Transition and Care Management (TCM) Program is another important joint VA–DoD resource for Veterans who have recently left the military and who are in need of mental health care. Each VA medical center has a TCM team, comprised of experienced and specially trained staff. Eligible Veterans are screened by TCM teams for case management needs, including services to address homelessness, unemployment, substance abuse, and MST. Servicemembers and Veterans who screen positive for any of these factors are assigned a case manager who works with them to coordinate the full spectrum of care, benefits, and services needed for optimal recovery and long-term well-being.

Additional joint VA-DoD outreach efforts target Servicemembers, Veterans and their families in their home communities. Examples include Yellow Ribbon Reintegration events, Post Deployment Health Reassessment events, Individual Ready Reserve annual screening musters, and VA Welcome Home events and job fairs.

Question: The claims backlog has long been a priority of mine. The FY17 Military Construction and Veterans Affairs spending bill continued monthly performance reports in an effort to focus the VA on solving this problem.

Question: The backlog recently increased from around 70,000 a few months ago to just over 94,000 as of April 29th. What caused this rise in the claims backlog?

VA Response: VBA ended FY 2016 with 71,690 claims pending more than 125 days, a number which climbed to 95,837 claims by the end of December 2017, an increase of approximately 24,000 claims. The volume of claims received from April to July 2016—claims that would age to 126 days or older between October and December 2016—increased 13 percent over the same period in the prior year, while at the same time, VBA's claims completions decreased by approximately 4.4 percent when comparing the first Quarter of FY 2017 to FY 2016.

VBA is taking a number of steps to correct this situation, including allocating more than 900 personnel to our claims processing teams to reduce the current backlog and improve the timeliness of non-rating claims. Other factors that will improve timeliness include increased contracting for medical examinations and technological enhancements to automatically establish claims, allowing them to be assigned for work sooner in the claims lifecycle.

Question: To what extent did the hiring freeze hurt efforts to reduce the claims backlog?

VA Response: The short duration of the hiring freeze, January 23, 2017 to March 17, 2017, translated to a negligible impact on disability compensation claims processing and the remaining inventory of claims in the backlog.

Question: The previous administration set eliminating the claims backlog as a major priority. What have you set as the goal for the current backlog, and what do you predict the backlog will be at the end of 2017?

VA Answer: VA continues to prioritize the backlog and work to process all claims within 125 days but acknowledges that, by their nature, some claims will take longer to complete. For disability compensation and pension claims completed through May 20, 2017, VBA has completed 77 percent of all claims in 125 days or less, an 8.3 percent improvement over the prior fiscal year. At the same time, total completes are up 2.4 percent. VBA looks to achieve a standard of service where more than 90 percent of all claims are completed within 125 days.

The inventory of claims pending over 125 days continues to be an important metric as we work towards more efficient processes. VBA believes that by the end of the fiscal year 2017, the inventory of claims over 125 days, identified as backlog by the prior administration, will be approximately 70,000 claims.

Question: For fiscal year 2017, this Committee funded the National Center for Post-Traumatic Stress Disorder (PTSD) at $40 million, a $21 million increase over the previous year. The Committee more than doubled the Center's budget because of its

strong work researching the effects of PTSD. With approximately eleven to twenty of every 100 veterans returning from Operation Iraqi Freedom and Enduring Freedom with PTSD, the Center will be called upon more than ever to create new and innovative ways to treat this deadly disorder.

Question: What research has been achieved as a result of the funding increase for the Center?

VA Answer: The National Center for PTSD used this supplemental funding to accelerate research and education on PTSD. In deciding how to use the funds, the Center prioritized novel, high-value projects that were feasible to implement within the one-year timeframe and to supplement key ongoing projects to enhance outcomes. These funds position the Center to make major advances in understanding the causes and consequences of PTSD and in the use of technology to deliver evidence-based care. In addition, the funding was used to create new educational products and an outreach campaign to engage Veterans in care for PTSD.

A significant portion of the funding was allocated to research on biomarkers—biological indicators to predict the development of PTSD, facilitate diagnosis, predict treatment response, and inform understanding of the mechanisms underlying PTSD. The funding has enabled the Center to greatly speed up research on these topics. Of the biomarker projects, the largest allocation of the funding helped the Center make its PTSD Brain Bank (the world's first brain tissue repository for PTSD) fully operational by acquiring more brain tissue, including tissue from comparison brains with no mental health problems and with depression. A major project using the brain tissue will examine four brain regions critical to PTSD, and will be the first ever to use brain tissue to perform RNA sequencing in these areas to examine gene expression unique to PTSD.

Other biomarker projects include genome-wide association studies, which are expensive and require large samples, to identify genetic variants associated with PTSD, epigenetic studies to examine modifications of gene expression associated with PTSD, plasma and cerebrospinal fluid assays to identify neurotransmitters, neurosteroids, and other biomarkers associated with PTSD risk and resilience, and neuroimaging to expand existing knowledge about alterations of brain structure and function in PTSD.

Another large project made possible because of the funding is the Longitudinal Investigation of Gender, Health, and Trauma (LIGHT) Study. This study will examine the effects of exposure to ongoing community violence and other traumatic events across the lifespan in a sample of 4,000 male and female Veterans. It will include both users and non-users of VA healthcare in order to better characterize the role of violence and lifetime traumatic exposure in the general Veteran population. The LIGHT study is unique in its focus on community violence in a large, nationally representative sample of Veterans, and also in its secondary focus to oversample women Veterans in order to provide key information about how trauma and PTSD relate to unique issues among women, such as reproductive outcomes.

In FY 2015, VA began a national initiative to implement measurement-based care in mental health. Using repeated standardized measures of symptoms and functioning to track patient progress and inform treatment decisions is not a routine practice in the field of mental health in either VA or non-VA settings. The National Center is using some of the supplemental funding to support VA's pioneering efforts in delivering measurement-based care by funding qualitative interviews with clinicians and Veterans to learn about barriers to and facilitators of implementation of measurement-based care. The funding is also supporting the development of a measure of Veterans' likelihood of engaging in PTSD treatment.

Some of the funding has been allocated to technology-based projects a particularly exciting project will enhance the training of providers in using the gold-standard diagnostic interview for PTSD, the Clinician-Administered PTSD Scale, or CAPS. Currently, providers learn how to administer the CAPS in an in-person workshop or by viewing on online course, but in order to become proficient they must practice and receive expert feedback on their performance—something that is cost- and labor-intensive. The project will develop an online program that allows clinicians to interact with a "virtual patient" to practice interviewing skills and receive real-time feedback on their performance. Virtual patient technology in PTSD is an important breakthrough that will expand VA's ability to train providers in optimal diagnostic assessment for PTSD.

Other technology projects are designed to enhance delivery of effective treatments and improve access to treatment. Three new apps are being developed to (1) support Veterans who experienced military sexual trauma, (2) improve relationship satisfaction in couples in which one or both partners have PTSD, and (3) enable Veterans to use exposure therapy, one of the most effective treatments for PTSD, in a self-help format (to enhance access and decrease stigma). Funding will also support infrastructure to create "research" versions of existing apps for PTSD in order to evaluate their clinical utility, and to produce an online platform that patients, providers, and policy-makers can use to optimize existing VA resources to increase timely access to evidence-based psychotherapies. The platform also will support several web-based self-help treatments VA has developed.

Finally, the National Center is launching an outreach campaign to identify, compare, and evaluate various strategies, including social media, for informing both public and professional audiences about NCPTSD products and engaging Veterans in seeking care for PTSD. The focus on comparing and evaluating strategies will enable the Center to optimize its outreach efforts in future initiatives.

Question: This Committee has spent years working with the VA and the Department of Defense (DoD) to implement an interoperable system that allows seamless transition of electronic health records from the Pentagon to the VA. It is distressing that, despite years of hard work by all parties, and tens of millions invested by this Committee, it seems we are no closer to achieving our goal.

Question: You have stated a decision will be made by July 1st on whether the VA will upgrade its current system, VistA, or partner with a commercial electronic health record product. Can you shed some light on your views of these options?

VA Response: The health and safety of our Veterans is one of our highest national priorities. VA is committed to providing seamless care for Veterans, including access to a complete EHR and shared, transparent care pathways. In order to ensure seamless care for Veterans, VA will move toward a single common system by adopting the EHR system that is being deployed by DoD, which at its core consists of Cerner Millennium.

[Questions for the Record submitted by Congresswoman Lee for The Honorable David J. Shulkin follows:]

Question: In 2016, the first ever National Veterans Health Equity Report found that all minority veterans were diagnosed with PTSD at rates higher than white veterans. This is consistent with what the VA National Center for Post-Traumatic Stress Disorder (PTSD) has found.

As the veteran population becomes increasingly diverse, the VA will need to make greater investments into research on to close health disparity gaps like this one.

What has the VA done to address this disparity and the high rates of PTSD in its minority veterans? What is the VA doing to address health disparities among its veterans? What sort of coordination exists between the Office of Minority Health and the VHA, if at all?

Question: The OIG testified in March to the Subcommittee that VA data sets on veterans' demographic data are not reliable because "definitions of race and ethnicity are sometimes not clear."

I am deeply concerned about this, because as our veterans population is rapidly diversifying and the VA needs accurate data in order to properly meet their needs.

Please describe the various processes that the VA uses to collect data on the racial and ethnic background of veterans, including: when data is collected from veterans; and the racial and ethnic categories available for veterans to use.

VA Answer: In accordance with the Paperwork Reduction Act, VA limits the collection of information to the minimum needed to determine eligibility for and delivery of benefits and services. Race and ethnicity are generally not required/requested data. When collected, VA complies with the OMB and Census standards for race/ethnicity which require five minimum categories for race (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) and for ethnicity, Hispanic or Latino origin.

What are obstacles that the VA faces in taking steps to standardize and clarify its processes for data collection on race?

VA Answer: There is no law or regulation prohibiting VA from collecting data on race/ethnicity directly from Veterans. However, the VA's ability to improve its data collection on race/ethnicity are predicated on the existing capabilities of various IT databases and the willingness of Veterans to report their race/ethnicity information.

Question: Last year, I was pleased to successfully include in the FY17 Military Construction and Veterans affairs appropriations bill report language requesting a quarterly report on the VA's work with "small, minority, and women-owned businesses."

Can you give me the status of these reports? I still have not received the first report that was due by March 2017.

Can you tell me what steps the VA has taken to ensure that veteran-owned, "small, minority, and women-owned businesses" have a fair chance at competing for VA contracts?

VA Answer: VA submitted the reports for the first and second quarters of Fiscal Year 2017. These reports describe the steps taken and the outcomes in terms of government contracting dollars awarded. These reports are also attached here.


2017 CTR - Small Minority and Women-

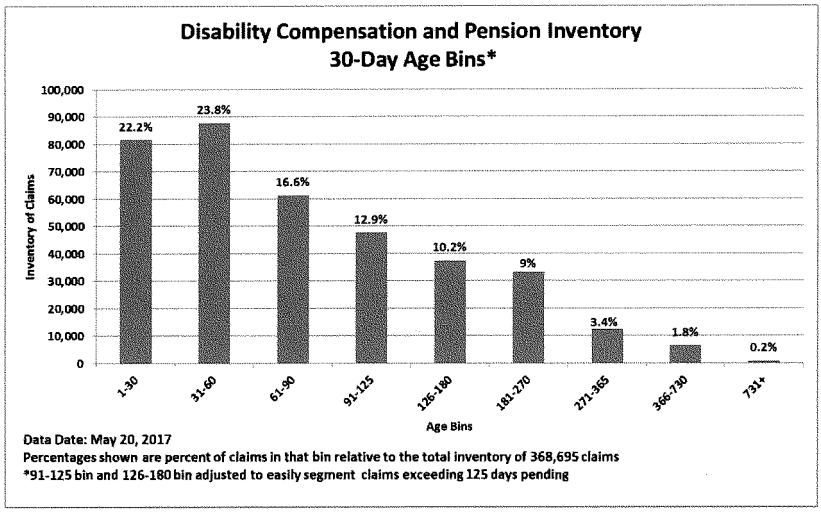

Adobe Acrobat PDFXML Document

Question: Can you give me an update on the number of informal claims currently backlogged at the Oakland VARO?

VA Answer: There are zero informal claims that are backlogged. By definition a claim does not count towards the inventory of claims until it is formalized.

Question: What is the average age of the claims backlogged? What is the range?

VA Answer: As of May 21, 2017, there are 90,407 disability compensation and pension claims that are over 125 days, which have been classified as "backlog." Because "backlog" is itself an age category and not a separate inventory or type of claim, the average age of claims pending in that subset would not be a valid measure. Currently, 24.5 percent of the entire pending inventory of disability compensation and pension claims are over 125 days. The following table shows the entire inventory of disability compensation and pension claims by 30-day age bins (excepting the 91-125 and 126-180 -day bins, which were drawn to easily segment claims that fall into "backlog"). The average age of all claims in this inventory is currently 97.3 days.



Question: How has the National Work Queue affected the claims backlog? Will it help streamline and reform benefits claims processing and the appeals process?

VA Answer: In 2016, VBA transitioned to the National Work Queue (NWQ), which nationally prioritizes and distributes rating claims to minimize the time to adjudicate a claim. The NWQ is designed to prioritize and distribute claims to stations matching their capacity and resources.

With the implementation of NWQ, VBA has employed and refined a capacity model to capture an accurate representation of available resources and skill sets. The capacity model sets a baseline for the NWQ on how many claims to push to each station at the development, rating, award, and authorization cycles on a daily basis. It ensures an equitable distribution of claims based on each station's available resources and national performance standards and national pending inventory.

Implementation of NWQ has improved cycle times for several phases of the claim processing process. Average time for initial development on a claim has improved from 22 days to 10.5 days. In the rating phrase, average time for rating decisions on claims has improved from 21 days to 7 days. In award and authorization, NWQ has improved timeliness by 1.5 days, down to 17.6 days. Combined, these improvements result in more timely service for Veterans and move VBA closer to the goal of processing 90% of claims within 125 days.

Efficiencies gained through the NWQ will be factored into decisions regarding future resource placement. VBA will continue to monitor performance to ensure Veterans continue to receive the most efficient service possible. VBA will also continue to analyze and adjust the resource allocation model (RAM) as new information becomes available and initiatives are implemented. Appeals are not yet distributed by NWQ; this workload is going to be included in the NWQ during FY 18.

Question: Women veterans have a suicide rate 2 to 5 times higher than civilian women. Now, we know that the veterans' health system was originally designed to serve only men.

So I'd like to know the steps the VA is taking to meet the needs of women veterans with regard to mental health and health issues?

VA Answer: VA is leading national efforts to understand suicide risk factors, develop evidence-based interventions strategies, and proactively identify and care for Veterans who are in crisis or at risk for suicide. VA conducts comprehensive evaluations of suicide deaths among Veterans, including gender differences in suicide rates and risk factors. VA is committed to ensuring that appropriate services are available to meet the treatment needs of women Veterans who may be at risk for suicide. For example, evidence-based therapies for posttraumatic stress disorder (PTSD), including prolonged exposure and cognitive processing therapy, have been shown to decrease suicidal ideation. These treatments are available at every VA medical center.

VA has numerous suicide prevention resources available, including a 24-hour per day Veterans Crisis hotline (1-800-273-8255), 24-hour Veterans Crisis Online Chat (http://www.Veteranscrisisline.net/ChatTermsOfService.aspx), as well as a suicide prevention-focused website with numerous resources for Veterans and their families (http://www.mentalhealth.va.gov/suicide_prevention/). Every VA medical center and large community-based outpatient clinic has a Suicide Prevention Coordinator, who serves as a local point of contact and is responsible for tracking appointments, and coordinating enhanced care between Veterans and providers.

More broadly, VA provides a full continuum of mental health services for women Veterans, including general outpatient, specialty, inpatient and residential rehabilitation treatment options. Outpatient services include mental health assessment, evaluation, pharmacotherapy, and individual, group and family psychotherapy. Some specialty care programs that target problems such as PTSD, substance use, depression, and military sexual trauma (MST) — each of which has been associated heightened suicide risk — include women-only services (e.g., women-only groups). Many facilities provide this care through specialized women-only outpatient treatment teams. For Veterans who need more intensive treatment and support, VA has residential programs that provide treatment to women only, or that have separate tracks for men and women. These programs are considered regional and/or national resources, not just a resource for the local facility. Mixed-gender options are also available. VA also has inpatient programs for acute care needs, such as psychiatric emergencies and stabilization, or

medication adjustment. More than half of VA mental health providers are female, and national policy strongly encourages all VA health care facilities to offer Veterans the choice of a provider of a particular sex for MST-related treatment whenever possible, and to offer all Veterans consultation with a same-gender provider for gender-specific concerns.

VA has enacted universal screening programs for common mental health conditions and related experiences — including those associated with increased risk for suicide — such as depression, PTSD, alcohol use, and MST. These screening programs provide an opportunity to identify individuals in need of mental health care and refer them to appropriate mental health services. Screening rates are very high, exceed private sector rates, and do not significantly differ by gender.

Strong clinical training initiatives are in place to ensure that mental health providers have the knowledge and skills to meet the unique treatment needs of the growing population of women Veterans. These include online resources, didactic teleconferences about issues specific to women's mental health — including a special series for mental health prescribers — expert clinical consultation, and interactive web-based trainings that use videoconferencing to facilitate psychotherapy demonstrations and role-playing between instructors and trainees. In addition, the first National Women's Mental Health Mini Residency was held in 2016. Approximately 200 participants representing nearly every VA medical facility nationally, as well as Vet Centers, attended this intensive, three-day training event. Nationally recognized experts led interactive sessions in a broad range of topics related to the treatment of women Veterans, including evidence-based psychotherapies and psychiatric medications. Specific training topics included treating women who have experienced gender-linked traumas, such as intimate partner violence and sexual abuse, working with women whose mental health problems are influenced by hormonal changes and the reproductive cycle, and understanding suicide risks in women Veterans. As part of this training, each participant developed an Action Plan to improve women's mental health delivery at their local facility. Each participant also now serves as a member of a national network of Women's Mental Health Champions, with a shared commitment to advancing gender-sensitive mental health services for women Veterans.

Question: For example, we've heard concerns that there are not enough OB and GYN serving women veterans. What has VA done to address this?

VA Answer: VA offers gynecology services to women Veterans at VA facilities. VA has 196 gynecologists employed with gynecologists on-site at 130 facilities. When these services are not readily available at a VA site or when VA facilities are inaccessible, this service may be offered to eligible Veterans through our Community Care program. The Community Care program is also used to provide sub specialty gynecologic (such as gynecological oncology, reproductive endocrinology, and infertility) and obstetrical (pregnancy and delivery services) to enrolled women Veterans as well as limited care to their newborns, as described and authorized by 38 U.S.C. § 1786.

Question: How can the VA's resource allocation policies be amended to make sure that women services members' health needs are adequately met?

VA Answer: The Veterans Equitable Resource Allocation (VERA) model fairly distributes the health care resources to the VISNs. The VERA model has undergone numerous Government Accounting Office, Price Waterhouse Coopers, and Rand studies which all have found that the VERA model is fair and equitable for the allocation of available resources. One key aspect of fairness is established through classifying patients into patient groups with similar resource demands. VA routinely reviews the underlying Veteran information to ensure that Veteran patient groups are fairly addressed in the allocation system. In 2015, women made up 9.4 percent of the Veteran population, with an expected increase to 16.3 percent by the year 2024. VA is making adjustments to its allocation/workload models ensuring resources are available to meet the growing female Veteran population within the VA health care system. VHA, for the first time, will create a gender specific patient group in the FY 2018 VERA model for women Veterans requiring Pregnancy/Obstetrics care. Additionally, VA recognizes female Veterans in its Enrollee Health Care Projection model, an actuarial model that projects future workload. VA will continue to ensure that adequate resources are allocated to ensure that women Veterans' health care needs are met across the system.

DEPARTMENT OF VETERANS AFFAIRS

APPROPRIATIONS COMMITTEES, SUBCOMMITTEES ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES

REPORT TO CONGRESS ON ITS EFFORTS TO WORK WITH SMALL, MINORITY AND WOMEN-OWNED BUSINESSES

FIRST QUARTER REPORT

Report Language:

Small, minority and women-owned businesses. The Committee directs the Department to submit a quarterly report to the Committee on its efforts to work with small, minority and women-owned businesses. The report shall specify the number of small, minority and women-owned businesses receiving contracts from funds appropriated under this Act, and the amount awarded to each small, minority and women-owned business receiving contracts from funds appropriated under this Act.

Report Citation: H. Rept. 114-497, page 57

Discussion:

I – EFFORTS TO WORK WITH SMALL, MINORITY AND WOMAN OWNED BUSINESSES

The mission of the VA Office of Small and Disadvantaged Business Utilization (OSDBU) is to enable Veterans to gain access to economic opportunity by leveraging the federal procurement system and enabling the participation of procurement ready small businesses. While the VA is Veteran centric in its mission focus, the OSDBU mission is inclusive of all small businesses and Veteran-owned programs. Efforts to work with minority and woman-owned small businesses, during the first quarter of fiscal year 2017 collectively revolved around the National Veterans Small Business Engagement (NVSBE). The NVSBE is a premier annual outreach event which offers a unique opportunity for businesses to build partnerships, maximize networking, and gain access to government procurement decision makers. The NVSBE accomplishes this by leveraging match making technology in order to directly connect procurement decision makers with procurement ready small businesses who possess capabilities that match mission needs. This engagement allows NVSBE attendees who register to meet their matches face-to-face during various roundtable sessions.

In addition to these networking activities, the NVSBE also offered robust learning sessions which covered a host of topics, specific to three tracks:

- Business Development
- Doing Business with Federal Agencies and Commercial Companies
- Advanced Procurement Strategies

Over three days, participants gained expert advice on both federal and commercial procurement processes and learned techniques to help grow their businesses. Learning Sessions strengthen

knowledge of procurement readiness by allowing experts to share their expertise and real-world strategies with small businesses. Sessions included a question and answer period. A summary of the specific topics offered include:

TRACK ONE – Business Development

1. eCommerce & Digital Marketing: Grow Your Business Globally
2. Top Notch Capabilities Statement - How to Market to the Federal, State, Municipalities and Prime Agencies
3. Finding Opportunities
4. Capability Statements and More
5. Small Business Tips From a Former Small Business Owner
6. International Expansion Blueprint - A Strategy for International Business Success
7. Globalize Your Website
8. Smartphone video: A Small Business Owner's Best Marketing Tool
9. Writing to Win
10. Better Results through Customer Experience
11. SBA's New Mentor-Program for all Small Businesses, including SDVOSBs
12. How To Effectively Take Advantage of Your Socio-Economic Status - It's Not What You Think
13. How To Engage and Position During Government Prospect Meetings
14. DSS's Small Business Strategy for Services Work
15. Why Corporations Require Veteran Certification
16. Certified? Now What?
17. Goldman Sachs 10,000 Small Businesses Information Session
18. Getting Ahead of RFPs
19. Commissioning Lessons Learned from VA Medical Facilities
20. T4NG - Is Your Business Ready?
21. Contracting, The Basics, from a Small Business Perspective
22. Networking, a Skill You Must Have to Win Contracts
23. Effective Presentation of Your Capabilities
24. Veterans and GSA contracts
25. Getting the Most out of your Mentor-Protégé Relationship: A Mentor's Perspective
26. Microsoft Excel - Easy tips for Making Excel work for You Without Having to be an Excel Guru
27. Integrated Master Schedule - Preparing, Maintaining, & Utilizing an Integrated Master Schedule for a Federal Contract
28. A Private Sector Sourcing Conversation with Veteran-Owned Businesses
29. Insider Out: Insider Perspectives on Pursuing and Winning Business at VA
30. Navigating Federal Background Requirements at VA
31. Personnel Security & Identity Management's Quick Tips for on-boarding at VA

TRACK TWO – Doing Business with the Federal Agencies and Commercial Companies

1. Doing Business with U.S. Nuclear Regulatory
2. The New Limitations on Subcontracting and the Non-Manufacturer Rule
3. Researching Federal Contracting Sources
4. Medical/Surgical Prime Vendor (MSPV) Program
5. Expand Your International Sales While Lowering Your Risk
6. GSA Schedules & More – A Business Perspective
7. Center for Verification and Evaluation Town Hall Meeting

8. Doing Business with the Missile Defense Agency
9. How to Become a Bigger SDVOSB & VOSB Without Violating the Law (Meeting the Requirements of Kingdomware with the Proven Joint Venturing Strategy used to Capture $13 Billion in Contracts for SDVOSBs.)
10. Working & Winning with a T4NG Prime - Anticipating VA IT Service Requirements for the Next Ten Years
11. Embracing Innovation and Breaking Silos - Creating a Seamless Customer Journey
12. WIRED! TO BID OR NOT TO BID?
13. Cost Effective Strategies for Minimizing Security Risks at VA Facilities
14. A Successful Project Designed and Built: A/E insight, tools and experience that add value during construction
15. Time for Some R & R - Understanding Responsiveness and Responsibility
16. Formula For Growth
17. Defining The Game-Bid, Capture And Proposal
18. Understanding the Wage-Hour Requirements for Government Contracts
19. Verification Town Hall
20. USBLN Certification- Fast Track to Commercial Business Opportunity
21. Effective and Compliant Teaming Agreements
22. SBA Size and Socioeconomic Programs: Myths vs. Realities
23. Overview on How to Request and Update DUNS/Business Information
24. Contract Disputes Act - What Every Contractor Needs To Know
25. Government's Duty of Good Faith and Fair Dealing
26. FOIA - The Reason Behind The Disclaimers
27. Everything You Need to Know About Protests
28. Affiliation: The Dirtiest Word in Federal Small Business Contracting
29. Prevailing & Minimum Wage Advanced Compliance Strategies: Using Fringe Benefit Requirement to Create Workforce Value and Competitive Advantage
30. Leveraging Business Partnerships to Drive VA Innovation
31. A Supply Chain Collaborative...Flown by American Airlines, Delivered by UPS and Fueled by Shell
32. You Won the Bid but How Do You Deliver? Managing a Successful Implementation with the VHA
33. The Benefits of FedRAMP
34. Is Your Capability Statement Hurting You?
35. Rule of Two – What it means for you
36. Open Source and Cloud Solutions
37. Trends and Opportunities in Federal Shared Services
38. Doing Business with Cox

TRACK THREE – Advanced Procurement Strategies

1. Making Teaming Agreements, Joint Ventures & Mentor-Protégé Agreements Work for You
2. The New Math – Limitations on Subcontracting
3. The Ins and Outs of the Non-Manufacturer Rule
4. SDVOSB Joint Ventures: A Legal Primer
5. Refresher on Construction Delays
6. Creating a Winning Approach for New Procurements: Lessons Learned from our Experience with HCATS
7. The Ostensible Subcontractor Rule – That's How They Getcha
8. Effective Negotiation

9. Health Care Analytics-Diabetes Prevalence and Incidence among the VA Health Care Users and VA Expenditures

In all, first quarter efforts to work with minority and woman owned small businesses consisted of a significant outreach initiative that included extensive networking and learning opportunities. The impact of these efforts, as reflected in event statistics, revealed that a total of 3,397 registrants physically attended the engagement. Of the total number of participants 86% (2,926 registrants) represented various small business socio-economic market segments (Table 1).

NVSBE Event Statistics	
Socio-economic Group	Number of Attendees
SBA 8(a)	209
HUBZone	149
Small Disadvantages Business	350
Service Disabled Veteran Owned Small Business	1,114
Veteran Owned Small Business	860
Woman Owned Small Business (WOSB)	244
Sub Total	2,926
Procurement Decision Makers	471
Total Attendees	3,397

Table 1 (Source: NVSBE 2016 Post Event Report)

II – CONTRACTS FROM FUNDS APPROPRIATED IN THE 2017 APPROPRIATIONS ACT

Contract obligations made to small businesses, to include minority and woman owned small businesses, are captured in aggregate below (Table 2).

First Quarter Obligations		
Socio-economic Group	Amount Awarded	Number of Contracts Received
Minority Small Business	$651,871,126	1,396
WOSB	$361,443,843	1,815
Total Small Businesses	$3,392,367,548	11,146
Minority Small Business % of Total Small Businesses	19.2%	12.5%
WOSB % of Total Small Businesses	10.7%	16.4%

Table 2 (Source: FPDS-NG Adhoc Report Run on 1/4/2017)

The dollar amounts and total number of contract awards reflected in table 2 account for 3,447 unique small business companies. Of the 3,447 small businesses accounted for in the first quarter, 567 of them additionally claim minority business status and 533 claim women owned

business status. To ensure accuracy in the data being reported, primary attributes and various filters have been applied. The data reflected in Table 2 focused on small business transactions that were in excess of the micro purchase threshold and were not the result of a follow-on to a previously competed contract action or strict sole-source transaction. The primary attributes singled out minority-owned and woman-owned businesses from among the total population of small businesses. The data was then filtered so as to include actions that were competed under:

- Simplified Acquisition Procedures (SAP)
- non-competitive SAP
- competitive delivery orders
- non-competitive delivery orders
- full and open competition
- full and open after exclusion of sources
- those designated as not available for competition

In summary, efforts to work with all socio-economic groups are an ongoing endeavor of the agency. And while the Small Business Administration (SBA) does not prescribe a Minority and Small Business Contracting goal for agencies to strive toward, VA will continue to work toward increasing business with socio-economic groups in kind.

References

MILCON VA Bill Quarterly Congressional FPDS Report
NVSBE 2016 Post Event Report
NVSBE 2016 Website https://nvsbe16.mybusinessmatches.com/

Provided By: The Office of Small and Disadvantaged Business Utilization

Date: May 2017

DEPARTMENT OF VETERANS AFFAIRS

APPROPRIATIONS COMMITTEES, SUBCOMMITTEES ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES

REPORT TO CONGRESS ON VA EFFORTS TO WORK WITH SMALL, MINORITY AND WOMEN-OWNED BUSINESSES

SECOND QUARTER REPORT

Report Language:

Small, minority and women-owned businesses —The Committee directs the Department to submit a quarterly report to the Committee on its efforts to work with small, minority and women-owned businesses. The report shall specify the number of small, minority and women-owned businesses receiving contracts from funds appropriated under this Act, and the amount awarded to each small, minority and women-owned business receiving contracts from funds appropriated under this Act.

Report Citation: House Report 114-497, page 57.

Discussion:

I – EFFORTS TO WORK WITH SMALL, MINORITY AND WOMAN-OWNED BUSINESSES

The mission of the VA Office of Small and Disadvantaged Business Utilization (OSDBU) is to enable Veterans to gain access to economic opportunity by leveraging the federal procurement system and enabling the participation of procurement ready small businesses. While the VA is Veteran centric in its mission, the OSDBU mission is inclusive of all small businesses and Veteran-owned programs. Efforts to work with minority and woman-owned small businesses during the second quarter of fiscal year 2017 revolved around five outreach engagements where VA supported Industry leaders and other federal agency partners. VA support consisted of the OSDBU workforce and guest speakers attending the various engagements. Specifically, outreach support was provided to:

- The Global Supplier Diversity Conference on January 26;
- The 2017 National 8(a) Association Conference on February 7;
- The Women As Veteran Entrepreneurs (WAVE) 7th Annual Women Veteran Small Business Seminar on March 16;
- The Veterans-In-Business Conference on March 23; and
- The U.S. Women's Chamber of Commerce Spring National Contracting Summit on March 30.

The purpose of the Global Supplier Diversity Conference is to educate Veteran and small businesses on various aspects of how to compete for contracts. The 2017 National 8(a) Small Business Conference is specifically tailored to small businesses, for the purpose to providing resources and information on how to navigate and capitalize on the ever-changing world of

federal contracting. The Annual Women Veteran Small Business Seminar is intended to provide attendees with opportunities to meet prime contractors and discuss business teaming, sub-contracting and mentoring. The Veterans in Business Conference is organized for the purpose of providing its attendees with unique exposure to many of the small business offices within the federal government along with commercial corporations that often need SDVOSBs to partner with them for various teaming arrangements. The last outreach event in the second quarter was the 2017 U.S. Women's Chamber of Commerce Spring National Contracting Summit, jointly hosted by the American Small Business Chamber of Commerce, offered a robust agenda which covered:

- Increased focus on helping small business federal contractors secure their fair share of federal contracting (taxpayer) dollars.
- Access to federal agencies and prime contractors.
- Timely education and information on current trends, opportunities and threats to small business contractors.
- Legal education important for teaming, joint ventures and related topics.
- Connections to potential teaming and joint venture partners.
- Influence on the Hill — connecting votes to action for our congressional leaders.

In all, second quarter efforts to work with minority and woman owned small businesses consisted of a series of targeted outreach initiatives that included extensive networking and learning opportunities. The impact of these efforts, as reflected in event statistics, revealed that a total of 927 registrants physically attended the collective engagements. The total number of participants in attendance at all outreach engagements for the various small business and socio-economic groups is reflected below.

Table 1

Second Quarter Event Statistics	
Socio-economic Group	Number of Attendees
SBA 8(a)	2
HUBZone	65
Small Disadvantages Business	0
Service Disabled Veteran Owned Small Business	210
Veteran Owned Small Business	490
Woman Owned Small Business (WOSB)	160
Sub Total	**927**
Procurement Decision Makers	N/A
GRAND TOTAL	**927**

(Source: OSDBU Strategic Outreach Communications Event Statistics)

II – CONTRACTS FROM FUNDS APPROPRIATED UNDER THE 2017 APPROPRIATIONS ACT

The numbers and amounts awarded to small, minority and women-owned businesses are captured below in aggregate.

Table 2

Second Quarter Awards and Obligations		
[illegible]	Amount Awarded	Number of Contracts Received
Minority Small Business	$814,760,634	1,484
WOSB	$463,760,698	1,803
Total Small Businesses	**$3,509,049,028**	**11,216**
[illegible]	23.2%	13.2%
Total Small Businesses		
WOSB % of Total Small Businesses	13.2%	16.1%

(Source: FPDS-NG Adhoc Report Run on 4/7/2017)

To ensure accuracy in the data being reported, primary attributes and various filters have been applied. The data reflected in Table 2 focused on small business transactions that were in excess of the micro purchase threshold and were not the result of a follow-on to a previously competed contract action or strict sole-source transaction. The primary attributes singled out minority-owned and woman-own?``ed businesses from among the total population of small businesses. The data was then filtered to include actions that were competed under:

- Simplified Acquisition Procedures (SAP)
- non-competitive SAP
- competitive delivery orders
- non-competitive delivery orders
- full and open
- full and open after exclusion of sources
- those designated as not available for competition

In summary, efforts to work with all socio-economic groups are an ongoing endeavor in the Department. And while the Small Business Administration (SBA) does not prescribe a minority small business contracting goal for an agency to strive toward, there are efforts to favor socio-economic groups in kind.

Prepared By: The Office of Small and Disadvantaged Business Utilization

Date: May 2017

Sources:

MIL-CON VA Bill Quarterly Congressional FPDS Report
OSDBU Strategic Outreach Communications Event Statistics

[Questions for the Record submitted by Congressman Ryan for the Honorable David J. Shulkin follows:]

Question: Further complicating the opioid over-prescription problem is a lack of appropriate software in our clinics. Your testimony mentions the need to upgrade our software and I couldn't agree more. I want to highlight that although there are proven clinical pharmacy surveillance software products specifically designed to assist clinicians in managing overprescribing of opiates, accidental addiction and overdose; I understand that we have not invested in a nation-wide technology solution and instead require VA medical facilities and VISNs to invest operating funds in IT solutions. The report on Opioid Addiction Treatment Protocols fails to recognize the Substance Abuse and Mental Health Services Administration's inclusion of non-opioid options for treatment of opioid substance use disorders. This includes options such as a non-opioid 30 day shot that is minimally invasive to Veterans lives and removes the high provided by opioids. I am deeply concerned that our opioid dependent veterans are not being offered the opportunity to become free of all opioids, and instead are simply being placed on opioid replacement medications such as methadone.

Question: What is the VA doing nation-wide to implement technology solutions to assist clinicians in delivering improved and preventative patient care so that opioid prescriptions and other medication are properly prescribed? Are there plans in place to follow the lead of the VA Medical facilities and VISNs who invested their own operating funds in commercially proven clinical pharmacy surveillance capabilities to drive their Antimicrobial Stewardship Programs and provide oversight to opioid prescriptions?

VA Answer: VA has developed an opioid risk assessment tool (STORM). This tool examines a variety of predictors to assess an individual's risk for adverse outcomes associated with opioid use. This has recently been made available to all providers and use is expanding. We will be applying this tool to review patients currently on opioids, as well as incorporating it into the management of new patients. We are seeking to automate the CARA required Prescription Drug Monitoring Program review for new opioid prescriptions and combine it with this tool to allow a single review for providers. At this point we have implemented a number of dashboards that allow us to examine and track prescribing patterns, at the medical center level as well as from central office. These include panel management tools (OTTR), the opioid safety dashboard, and the academic detailing dashboard, that allows review of provider practice patterns. These tools are all deployed, and allow us to track the outstanding reductions in opioid use and improvements in safe prescription practices the VA has made.

VHA already has standardized national reporting of key outcome data for health care-associated infections (HAI) and facility-level antimicrobial use through VHA's Inpatient Evaluation Center (IPEC) and CDC's National Healthcare Safety Network (NHSN) Antimicrobial Use (AU) Option, respectively. All VHA facilities nationwide report HAIs due to multi-drug resistance organisms, including Clostridium difficile infections (CDI) and methicillin-resistant Staphylococcus aureus (MRSA), to VHA's web-based IPEC

data management portal. The data gathered through this process, and published in the peer-reviewed medical literature, have demonstrated reductions in MRSA HAIs in VA hospitals by 80 percent over an 8-year period and about a 50-percent reduction in VA long term care facilities (at http://doi.org/10.1016/j.ajic.2016.08.010), along with declines in CDI in hospitals (at https://doi.org/10.1017/ice.2016.27) in addition to reductions in hospital-onset Gram-negative organism bacteremia (https://doi.org/10.1093/cid/ciw423).

Also VHA, supported by a grant from CDC, continues to increase participation in NHSN AU Option reporting with enrollment available to all VHA facilities. Currently, well over half of all VHA acute care facilities are in the process of or have completed validation and successful submission of antibiotic use data to NHSN. The data generated by both HAI and AU reports are available to local antimicrobial stewardship champions and are essential to monitoring the impact of local stewardship programs. Lastly, VHA has ongoing development efforts for additional nationwide electronic tools to support infection prevention and control and antimicrobial stewardship programs.

Question: What is the VA doing to ensure that veterans have the opportunity to truly become free of all opioids, and are offered the full range of opioid addiction treatment medications approved by the Food and Drug Administration as established in the SAMHSA Practice Guidelines?

VA Answer: VA has implemented a number of programs to address the epidemic of opioid related adverse events which leverage our nationwide electronic medical record system to provide technology solutions to assist patients, providers and facility leadership in improving the safety of opioid prescribing. In fact, from approximately October 2012 through March 2017, there are 221,773 fewer Veterans receiving opioid prescriptions from VA.

1. VA's **Opioid Safety Initiative (OSI)** was implemented nation-wide in August 2013, and is producing the intended results. The basis for the OSI is to make the totality of opioid use visible at all levels in the organization using technology solutions. The OSI dashboard includes key clinical indicators such as the number of VA pharmacy users dispensed an opioid, the number of VA pharmacy users receiving long-term opioids who also receive a urine drug screen, the number of VA pharmacy users receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average morphine equivalent daily dose (MEDD) of opioids. Overall, VA has seen a 39 percent reduction in the number of Veterans who have received opioids for greater than or equal to 90 days.

2. VA deployed two state-of-the art technology decision support tools to help providers manage risk for Veterans receiving opioids. These tools are available now to all staff in VA facilities.

a. The **Opioid Therapy Risk Report (OTTR)** is a national dashboard, easily accessible through a direct link in the electronic health record, assists the primary care Patient

Aligned Care Teams (PACT) to manage their entire panel of patients' prescribed opioid therapy for acute or chronic pain. It includes information to help providers review and manage complex patients, including the dosages of opioids and other sedative medications, co-morbid mental health diagnosis, last primary care encounter, mental health and substance abuse clinic visits if applicable, most recent urine drug screen and informed consent date, significant medical problems that could contribute to an adverse reaction and a six month graphic look-back at opioid prescribing and pain scores. This gives providers a quick but thorough assessment of their patients' opioid risk for adverse outcomes and facilitates more effective care coordination and case management. Data in OTTR is updated within 24 hours which makes it easy to ensure that Veterans are receiving safe, quality care.

b. The **Stratification Tool for Opioid Risk Mitigation (STORM)** uses medical record data and a predictive risk model to estimate the potential risk of future overdose or suicide-related events in patients receiving a VA opioid prescription. This model greatly increases the efficiency of identifying patients at elevated risk so they can receive proactive care management and review, in comparison to identifying these patients based on individual risk factors, such as high opioid dose. The STORM report is updated nightly and facilitates risk stratified patient monitoring, presenting model-based estimates of likelihood of an overdose/suicide-related event, information on clinical and prescription risk factors, and a tailored checklist of recommended risk mitigation strategies, and information for care coordination. Providers can quickly review all patients to whom they prescribe opioids, prioritized based on risk estimates, to identify medications received from other providers, and address unutilized risk-mitigation strategies. STORM can also provide risk estimates for any VHA patient considering opioid therapy, estimating their risk of adverse events if they were to initiate a low, medium or high dose trial of opioid medication. These estimates can help guide risk-benefit discussions and shared decision-making regarding pain management plans.

c. VA has implemented the **Psychotropic Drug Safety Initiative (PDSI)** to foster quality improvement efforts for mental health prescribing by identifying and prioritizing areas for quality improvement at each medical facility. This VA initiative monitors over 20 mental health prescribing quality metrics at the facility level, including use of medication assisted treatment (MAT) for patients with opioid use disorder (OUD). Increasing access and use of MAT for OUD and other pharmacological treatments for substance use disorder is the focus of PDSI Phase 3. Facilities' quality improvement efforts are supported through identification of patients who may benefit from MAT, informatics tools, clinician education and dissemination of innovative models of care to increase capacity, technical assistance, and action planning guidance by a national team. Nightly updated reports provide customizable lists of patients with potential non-optimal prescriptions for review and intervention.

VA has also implemented other interventions to assist clinicians in delivering improved and preventative patient care so that opioid prescriptions and other medication are properly prescribed:

1. VA implemented the **Opioid Overdose Education and Naloxone Program (OEND)**. As of July 25, 2017, VA had dispensed over 92,000 naloxone kits to Veterans at risk of an opioid overdose -- a key objective of VHA's safety initiatives. Prescribers may provide OEND to Veterans they identify as benefiting from naloxone and opioid overdose education. Opportunities to identify high-risk patients for opioid overdose are available nationally through the OTTR or STORM. Substance use disorder providers are also being engaged via Academic Detailing educational outreach to create awareness and provide educational resources for patients diagnosed with OUD. Naloxone kits are available as intranasal, intramuscular, or auto injector delivery formulations, and the kits are available to all facilities through dispensing from the pharmacy or via mail through VHA's Consolidated Mail Outpatient Pharmacy.

   Academic Detailing is a service for clinicians by clinicians that utilizes motivational interviewing and other communication techniques in an individualized educational session to understand a clinician's understanding, attitudes, and motivations regarding specific clinical topic areas, to engage clinicians in practical change discussions. Moreover, VA's Academic Detailing Service has implemented complementary data reports that clinical pharmacy specialists trained in academic detailing can utilize to help identify providers with the most opportunity for change – those with the highest number of Veterans on opioids, most Veterans with the highest risk for overdose as measured by the risk index for overdose or serious opioid-induced respiratory depression (RIOSORD) scores, most Veterans with the highest STORM scores, or other high risk categories such as high dose opioids (>= 90 MEDD) and concomitant opioid / benzodiazepine prescriptions. This report was designed to utilize resources from both OTRR and STORM to provide a single seamless definition between VA resources. Additionally, this was specifically developed for the VISN academic detailers who then meet and discuss with individual providers to learn what barriers and challenges exist that are impacting their prescribing behavior.

2. I was relieved to hear you state recently that the VA is moving out of the business of generating IT software and to read in your written testimony the importance on updating our software systems. One area this antiquated IT structure has been hindering our Veteran care is in the area of preventing healthcare associated infections. The Joint Commission's Medicated Management Standard states that programs and hospitals that do not have an Antimicrobial Stewardship Program risk losing their Joint Commission accreditation starting this past January. Despite this issue, and an Executive Order, and a Veterans Healthcare Directive, I understand that there is no coherent, consistent system used across the VA to manage healthcare associated infections and prevent antibiotic –resistant super bugs. There isn't even consistent funding allocated to correct this issue in our VA clinics. The urgency of this issue came to light during recent news reports that nearly 600 patients from Tomah VA Medical Center in Wisconsin were exposed to HIV, Hepatitis B and C due to improper sterilization. Research also indicates implementing an effective program will result in overall cost savings by reducing hospital stay times, reducing clinical surveillance

requirements, reducing mortality, and can save over a hundred hours each month for our providers.

Question: With the rising risk of antibiotic resistant superbugs, does the VA have a coherent and consistent standard for real time prevention of healthcare associated infections and antimicrobial resistance? Is there a nationwide Infection Control and Pharmacy monitoring system? What can we do to provide oversight for compliance within the VA to reduce Healthcare Associated Infections and Antibiotic Stewardship?

VA Answer: VHA's Antimicrobial Stewardship Initiative began in mid-2010 and became formalized with the chartering of the VHA National Antimicrobial Stewardship Taskforce (ASTF) in March 2011. The purpose of this national effort is to support local development and augmentation of stewardship programs. The ASTF has developed numerous highly utilized field resources, including an educational teleconference series, electronic resources (Stanford Guide® Online and a National Stewardship SharePoint® site), in addition to example stewardship intervention policies for local adaptation and implementation. VHA Directive 1031, Antimicrobrial Stewardship Programs, signed January 2014, required all VHA facilities to establish antimicrobial stewardship programs with identified provider and pharmacy stewardship champions.

A national survey regarding VHA's local antimicrobial stewardship programs, developed in conjunction with the VHA Healthcare Analysis and Information Group (HAIG), was performed in 2012 and again repeated in late 2015. This survey was designed to obtain a comprehensive understanding of ongoing stewardship efforts at all VHA facilities and assist with identifying additional stewardship target areas to address. An evaluation of facility stewardship structure and practices reported in the 2012 survey was utilized to correlate key characteristics with antimicrobial usage. This evaluation was published in Infection Control and Hospital Epidemiology in June of this past year. (Infect. Control Hosp. Epidemiol. 2016;37(6):1-8).

The Centers for Disease Control and Prevention's (CDC's) core elements for antimicrobial stewardship were developed years after VHA began its Antimicrobial Stewardship Initiative. The eight core elements are: Leadership, Commitment, Accountability, Drug expertise, Action, Tracking, Reporting and Education. The CDC's core elements are in alignment with the antecedent VHA Directive 1031. The results of the 2015 VHA HAIG stewardship survey showed significant increases in numerous stewardship activities across the VA and improved performance rates. Specifically improvements were noted in identification of provider and pharmacy stewardship champions, performance of annual evaluations of the stewardship program and provision of face-to-face provider education.

Question: The VA spent $40M in the failed attempt to develop a Healthcare-Associated Influenza Surveillance System designed to manage infection prevention in the VA. Will the VA implement a software solution to provide infection prevention and control, microbial stewardship, clinical pharmacy surveillance and opioid management?

VA Answer: Data from the VA's Office of Information and Technology's Corporate Data Warehouse (CDW) have been used to standardize antimicrobial use reports. VHA continues to increase submission of facility-level inpatient antibiotic use data to CDC's National Healthcare Safety Network (NHSN) Antimicrobial Use (AU) Option. This effort has been supported by a grant from the CDC. Currently 83 of the 130 VHA acute care facilities are in the process of enrollment or have completed validation and successful submission of antibiotic use data to NHSN. VHA also has an ongoing pilot project supported by the CDC to determine system capabilities for reporting to NHSN's antimicrobial resistance option.

Key members of the VHA Antimicrobial Stewardship Initiative monitor aggregate antimicrobial use. There has been a significant 12% decline in inpatient antibiotic use since the inception of the Stewardship Initiative. Also during this period VHA 30-day readmission and mortality rates decreased intimating no untoward consequences of decreased antibiotic use. A report of the efforts of the VHA Antimicrobial Stewardship Initiative detailing this success has been published (Infect. Control Hosp. Epidemiol. 2017 May; 38(5):513-520).

In addition to the Antimicrobial Stewardship Initiative, VHA has a complimentary program addressing antibiotic resistant organisms, the VHA Multidrug-Resistant Organism (MDRO) Prevention Initiative. The MDRO Prevention Initiative, established in 2007, monitors infection and death rates due to specific resistant organisms and has created numerous targeted prevention initiatives. This Program has demonstrated highly publicized successes in reductions of methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile infections and maintains an active program for the control of carbapenem-resistant Enterobacteriaceae. In January 2017, an evaluation of 8 years of the MRSA Prevention Initiative published in American Journal of Infection Control (Am J Infect Control 2017;45[1]:13-16) has demonstrated an over 80% reduction in MRSA healthcare-associated infections in the acute care setting of VHA (ICUs, non-ICU acute medical-surgical units, and spinal cord injury units), and nearly a 50% reduction in VHA's community living centers.

Clostridium difficle infection in the United States has been associated with increased morbidity and mortality especially in older persons. Therefore, a nationwide CDI Prevention Initiative was begun on July 1, 2012. Rates of clinically confirmed, hospital-onset healthcare facility associated Clostridium difficile infections from July 1, 2012 through March 31, 2015, in 127 acute care Veterans Affairs facilities were evaluated. Quarterly pooled national standardized infection ratios decreased 15% from baseline by the final quarter of the analysis.

1. As you are aware, May is Mental Health Month. As co-chair of the Military Mental Health Caucus, I became aware recently of the shortage of licensed professional mental health counselors. These counselors have masters degrees and are fully certified, yet this resource is still underemployed at the VA. In FY 2015 there were only 72 licensed mental health counselors and in 2016 this number dropped to 64. By comparison, there are over 12,000 social workers. While both are important fields, I do not understand why we have hired so few mental health counselors at a time when our Veterans need access to mental health care more than ever. MOAA's study assessing the Health of Those Who Served finds that 16% of Veterans have been diagnosed with a depressive disorder. A recent RAND study indicated our younger Veterans may be at an even higher risk for depression with up to 22% of post 9-11 Veterans struggling with depression.
    a. Will the 2018 budget include attention to hiring more licensed mental health counselors?

VA Answer: Beginning on September 28, 2010, VA facilities were authorized to hire Licensed Professional Mental Health Counselors (LPMHC) as specialty mental health providers. This was after Congress recognized LPMHCs as a specific occupational category of mental health specialists in the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109-461). The addition of LPMHCs to the VA mental health workforce has expanded VA facilities' staffing options and enabled VA to better meet the needs of a Veteran population increasingly in need of mental health care services. As VA's demand for mental health professionals grows, we expect that VA will continue to successfully recruit LPMHCs into its mental health workforce. It is important to understand that LPMHCs are still a relatively new profession within VA and decisions to hire into this occupation are made at a local level, so the pace of hiring of this profession may vary from site to site. The number of LPMHCs hired with the VA continues to increase. At the end of FY15 there were 189 LPMHCs onboard; at the end of FY16 there were 237 LPMHCs onboard and at the end of April 2017 there were 264 LPMHCs onboard.

As many mental health leaders in VA still are not as familiar with the LPMHC profession and may not be aware of the roles that LPMHCs are able to serve, VHA Mental Health Services (MHS) has presented to VISN and facility level mental health leadership and local human resources staff about the benefits of hiring LPMHCs and has provided a detailed power point presentation about the LPMHC profession. These presentations included information that LPMHCs are considered one of the "core mental health professions" within the VA (other core mental health professions include psychology, psychiatry, social work, marriage and family therapist and nursing). While Mental Health Services will continue to support the hiring of all mental health professionals, there is not an increase in the budget to hire this specific discipline.

2. Our Nation's veterans deserve the very best support that is available, not only in the actual provision of health care, but in the business processes and systems with which all the services and supplies are purchased with which support VA's mission to provide that health care. eCMS is used today and provides that level of sophistication and modernity. Replacing eCMS with a system which is less capable or functional, and then paying the new provider untold $millions to upgrade their system to a point where eCMS is today is, on its face, a poor financial and operational decision which will undoubtedly have a negative impact of veterans health care. VA needs to fix their real problem...the financial management system .... and not create additional problems for itself by replacing eCMS with another contract management system which will not meet VA's needs without significant, time-consuming and (unbudgeted) expensive customizations.

Question: TO YOU: We understand that in March 2017, the House Committee on Veterans Affairs sent you a letter outlining a number of concerns regarding the VA's intention of satisfying your financial and acquisition management system needs by using the shared services arrangement offered by the US Department of Agriculture. We share similar concerns, especially in regards to the displacement of VA's Electronic Contract Management System (eCMS) with a system which may be less functional or capable, thus requiring VA to spend untold $millions to bring the system up to the standard that eCMS is at today. eCMS is a state-of-the-art web-based solution and is being used successfully across the Nation and has integrated with other business systems. Please inform the Committee of your plans and schedule to perform a detailed functional and capabilities analysis comparing eCMS with the intended replacement system.

VA Answer: VA has a clear and urgent need to modernize its 30-year-old, legacy *financial management environment. Upon careful and extensive analysis, VA* acknowledges the current environment cannot be patched or enhanced without significant effort. Many of VA's long-standing reported material weaknesses and deficiencies have resulted from the use of non-integrated disparate acquisition and financial systems and the inherent limited functionality. The lack of integration between eCMS and the legacy financial system alone directly contributes to two of the six material weaknesses and represents one of two significant deficiencies in VA's annual federal financial statement audit.

Today's environment includes continued reliance on extensive manual processes, reconciliations and journal entries to produce a set of auditable financial statements. The lack of an integrated system is directly attributable to non-standardized business processes and manual data entry. To address this disparate environment, VA is undertaking a discovery and analysis of the nearly 100 interfaces to determine which will be retired or reworked to complement the selected solution. In addition, there is significant risk to the Department due to the lack of common data elements to facilitate reconciliation and flow of information between the acquisition and financial system.

VA needs a state-of-the-art integrated enterprise resource planning solution to resolve audit deficiencies and gain efficiencies. Migrating to a modern, integrated shared services solution addresses many of these concerns to include mitigating the risk of material errors in financial statements, reconciling interagency agreements to the balances reported in financial statements, and remediating prior year recovery reconciliations. An integrated financial and acquisition solution will increase the transparency, accuracy, timeliness and reliability of financial information resulting in improved fiscal accountability to American taxpayers. This includes reducing improper payments and the use of miscellaneous obligations; ensuring data accuracy and quality data within feeder systems, strengthening internal controls, timely recording and recognition of obligations; and improving financial and acquisition reporting and analytics to meet federal regulations such as the DATA Act.

In partnership with USDA, the focus remains on standardizing business processes within a single, integrated solution that meets the entire spectrum of financial and acquisition requirements to better serve Veterans and the employees of the Department who serve them.

WEDNESDAY, MARCH 22, 2017.

OVERSIGHT HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

WITNESS

HON. MICHAEL J. MISSAL, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

CHAIRMAN DENT OPENING STATEMENT

Mr. DENT. Good morning, everybody. Thank you for coming out to this hearing, and I appreciate all your attendance.

And since the full fiscal year 2018 budget hasn't arrived, we thought it would be useful to begin our VA hearings with a hearing focused on oversight issues. And the VA Office of Inspector General is really ground zero for oversight of veterans health and benefits.

Mr. Missal, we are delighted that you are here, and we are glad the previous administration finally got around to making your VA IG appointment. I know that you were confirmed in April of last year, and so we were treading water far too long with an acting IG.

And I understand you actually sought out this appointment, leaving the private sector to take this job, which is a very brave move, considering all the problems the VA has had and the volume of work that awaits you.

We will be interested in the changes you have implemented to sharpen the focus of the IG's work in the areas you believe are most important in VA operations.

We will include your full statement in the record and will appreciate your limiting your oral remarks to about 5 minutes.

But before we ask you to begin, I will turn it over to our ranking member, Ms. Wasserman Schultz, for any remarks she might have this morning.

RANKING MEMBER WASSERMAN SCHULTZ OPENING STATEMENT

Ms. WASSERMAN SCHULTZ. Thank you very much.

It is good to see you again. Thank you for coming.

Clearly, the Inspector General plays a vital role in ensuring that VA programs are implemented properly and that funds appropriated by this committee are spent wisely and in accordance with the law. And I really was very pleased with our conversation. It is very clear that you understand exactly what your mission is and are focused on it. And I look forward to working with you as we continue to address the issues that still persist at the VA and that we hold any and all bad actors accountable.

We still have veterans waiting too long to receive both care and benefits, and it is well past the time for a cultural change at the VA and one that more vigorously embraces strong oversight.

The Office of the Inspector General was integral in investigating and responding to the 2014 Phoenix scandal, and in response to this investigation, which uncovered numerous issues, Congress passed the Veterans Choice Act.

The Office of the Inspector General was also crucial in examining the cost overruns at the Denver Medical Center, where the project costs increased from $604 million to $1.7 billion.

Most recently, the IG has helped identify extremely troubling and wholly unacceptable issues at the Veterans Crisis Line. According to the report that was released this week, the Crisis Line continues to send nearly a third of its calls to outside backup centers. And I see that the VA released a new figure, that that is now at 1 percent, and I look forward to asking you about the discrepancy between what your analysis is and what this statement reflects. But that number was very significant, even in spite of opening a second call center designed to reduce that backlog.

The concerns that I have about the Veterans Crisis Line already were confirmed by our visit to the D.C. VA Medical Center the other day, because during a presentation on mental health, we received conflicting responses on training and protocol for employees at the Veterans Crisis Line.

Mr. Chairman, I know you agree that it is critical for the IG to have the necessary resources to conduct aggressive oversight and ensure that our veterans receive the health care they both deserve and need and receive such care in a timely fashion. No matter what steps the VA takes to address the challenges it faces in delivering health care, the VA will be unable to do so without proper oversight. Oversight and true reform lie squarely with Congress and the Inspector General, working together.

Mr. Missal, I commend your work thus far, but I think we would both agree that there remains much to be done to repair both our veterans' and our Nation's trust in the VA system.

And, again, thank you for being here today, and I look forward to working with you to address these issues.

Mr. Chairman, I yield back.

Mr. DENT. Thank you. I thank the ranking member.

Let's go right to Mr. Missal.

And we look forward to receiving your testimony. Please, you are recognized.

Mr. MISSAL. Thank you.

HON. MICHAEL J. MISSAL OPENING STATEMENT

Mr. Chairman, Ranking Member Wasserman Schultz, and members of the subcommittee, thanks for the opportunity to discuss the oversight the Office of Inspector General provides to VA programs and operations.

I have had the great honor and privilege of serving as the IG since May 2016, and today is my first opportunity to testify before this subcommittee.

I would first like to thank the Congress for the increase in our fiscal year 2017 appropriation. Our fiscal year 2018 appropriation

of $159.6 million will greatly assist our ability to fulfill our mission of effective oversight of the programs and operations of VA.

Although I did not come into this role with any preconceived notions of specific changes to make, I stated to the staff on my first day that we will always strictly adhere to the following three principles:

First, we must maintain our independence and make sure that we do not have even the appearance of any impairment to our independence.

Second, we must be fully transparent by promptly releasing reports of our work that are not otherwise prohibited from disclosure.

Third, we must maintain the highest integrity of our work. This means that each of our reports must meet at least the following five standards: It must be accurate, it must be timely, it must be fair, it must be objective, and it must be thorough.

In the past 10 months, we have made or are in the process of implementing a number of enhancements to our operation. Several of these initiatives represent concerted efforts by us to focus on the high-risk areas throughout VA, with the goal of being more proactive in our oversight. I believe that these changes will enable us to perform more impactful work in a timelier manner.

We are a relatively small office compared to other Federal OIGs as a percentage of both the agency's full-time-equivalent staffing and budget. We are comprised of approximately 725 full-time employee equivalents organized into five major directorates: Investigations; Audit and Evaluations; Healthcare Inspections; Contract Review; and Management and Administration. About 225 employees are based in Washington, DC, while the remaining 500 are dispersed throughout our approximately 40 field offices nationwide.

Since fiscal year 2014, we have received approximately 39,000 contacts to our hotline annually. Each year, we average about 350 reports and other work products, 475 arrests, 330 convictions, and $3.125 billion in monetary benefits.

Our return on investment averages $30 for every $1 expended on our oversight. This is a strong return and supplements the inestimable value we bring by helping VA improve its health care and benefits services that impact so many lives.

We crafted our fiscal year 2017 appropriation with the intention and hope that it will be the first of several tiered increases to right-size our office over the next several years. The expansion plan would increase staff to 1,160 by fiscal year 2021 and bring us to a level more equivalent with the increase in staffing and resources at VA and comparably situated OIGs.

In consideration of the hiring freeze and the administration's anticipated efforts to scale back the size of the Federal Government, we reduced our fiscal year requirements by $27 million from the $197 million figure submitted last year as part of our 3-year expansion plan.

Our budget request for fiscal year 2018 of $170 million, coupled with the anticipated fiscal year 2017 carryover, will cover the costs of normal inflation assumptions and at least 100 additional staff over fiscal year 2017.

The administration is proposing to straight-line funding for 2018 and 2017 enacted levels for a number of VA discretionary pro-

grams. Under this scenario, our fiscal year 2018 budget would be $159.6 million, the same as 2017.

This funding level overlooks potential inflation costs of at least $3 million for staff pay raises and infrastructure. Although we do not project that our operations would be adversely impacted at this funding level for 2018 because of available carryover funds, for subsequent years we would likely need to request a significant increase to our current funding to maintain current operations.

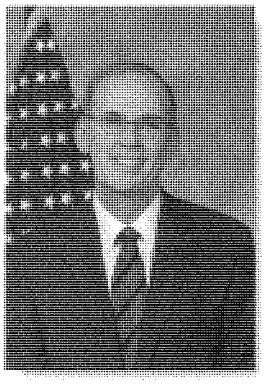
In conclusion, with continued support from Congress, we look forward to increasing our ability to conduct impactful oversight of VA programs and operations for the betterment of our veterans, their families, and American taxpayers.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you may have or other members of the subcommittee.

[The information follows:]

Department of Veterans Affairs
Office of Inspector General

MICHAEL J. MISSAL
INSPECTOR GENERAL
U.S. DEPARTMENT OF VETERANS AFFAIRS



The Honorable Michael J. Missal was nominated by President Barack H. Obama to serve as the Inspector General of the Department of Veterans Affairs (VA) on October 2, 2015, and confirmed by the Senate on April 19, 2016. He assumed responsibility as Inspector General on May 2, 2016.

As Inspector General, Mr. Missal directs a nationwide staff of auditors, investigators, inspectors, and support personnel. His office conducts investigations, audits, inspections, evaluations and health care evaluations to promote economy and efficiency in VA programs and to prevent and detect criminal activity, waste, abuse, and mismanagement.

Prior to being sworn in as Inspector General, Mr. Missal was a Partner at K&L Gates LLP, a position he held since 1991. He was a member of the K&L Gates Management Committee and also served as Co-Leader for the K&L Gates Policy and Regulatory Practice Area.

Prior to joining K&L Gates in 1987, Mr. Missal served as Senior Counsel at the U.S. Securities and Exchange Commission in the Division of Enforcement from 1983 to 1987. From 1982 to 1983, Mr. Missal served as a Law Clerk for Chief Judge H. Carl Moultrie I of the Superior Court of the District of Columbia. He served in the Carter Administration from 1978 to 1981, initially as a Staff Assistant to Assistant to the President Anne Wexler and then as a Law Clerk to Counsel to the President Lloyd Cutler.

Mr. Missal received a Bachelor of Science degree with Special Attainments in Commerce from Washington and Lee University and a Juris Doctor degree from the Catholic University of America.

STATEMENT OF MICHAEL J. MISSAL
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
OVERSIGHT HEARING ON THE
DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

MARCH 22, 2016

Mr. Chairman, Ranking Member Wasserman Schultz, and Members of the Subcommittee, thank you for the opportunity to discuss the oversight the Office of Inspector General (OIG) provides to VA programs and operations. I have had the great honor and privilege of serving as the VA Inspector General since May 2016, and today is my first opportunity to testify before this Subcommittee. My statement will focus on the OIG's mission, some of the more significant enhancements we have recently made and our more meaningful oversight work that we reported on during the past fiscal year. I would first like to take this opportunity to thank the Congress for the increase to our fiscal year (FY) 2017 appropriation. Our FY 2017 appropriation of $159.6 million will greatly assist our ability to fulfill our mission of effective oversight of the programs and operations of VA in the face of the tremendous challenges and expanded growth of many mission critical programs in VA.

Although I did not come into the role of the VA IG with any preconceived notions of specific changes to make, I stated to the staff on my first day that we will always strictly adhere to the following three principles. First, we must maintain our independence and make sure that we do not even have the appearance of any impairment to our

independence. Second, we must be fully transparent by promptly releasing reports of our work that are not otherwise prohibited from disclosure. Third, we must maintain the highest integrity of our work. This means that each of our reports must meet at least the following five standards: (i) they must be accurate; (ii) they must be timely; (iii) they must be fair; (iv) they must be objective; and (v) they must be thorough.

I wanted to learn as much as possible, in as short a time period as possible, about the OIG office, the Department and stakeholders. Since I began, I have visited 16 of my offices across the country, as well as a number of VA Medical Centers and Regional Offices. As part of my transition as IG, I also met with all of the senior leaders of VA, with the Comptroller General of the United States, with the Special Counsel of the United States, with members of Congress and their staff, and with the leadership of a number of VSOs. All of these meetings were productive and informative.

MISSION, VISION, AND VALUES

One of the first areas where I felt the OIG could improve was to restate our mission statement and articulate our vision and values. To this end, we published a Mission, Vision, and Values statement in September 2016, which is included at the end of the statement, and is available on our public website.[1] I have emphasized to my staff that we will strictly adhere to all tenets of our Mission, Vision, and Values statement and that it will be the guiding principle for all of the work we do going forward. Briefly, let me explain the more significant aspects of our mission, vision, and values.

[1] See https://www.va.gov/oig/about/vaoig-mission-vision-values.pdf.

Mission. Independent oversight is the core of every OIG's mission. We conduct effective oversight of VA programs and operations through independent audits, reviews, inspections, and investigations. Our work and recommendations identify opportunities to drive economy, efficiency, effectiveness, and integrity throughout VA programs and operations. Our ultimate goal is to help VA deliver quality and timely healthcare and benefits to our nation's veterans and their families, and to spend taxpayer money as appropriated.

Vision. With respect to our vision, which is how we accomplish our mission, there are a few items I would like to highlight. First, we are proactive in identifying potential issues. While we have more referrals than we can take, we also work on matters that we identify through proactive measures. We have a data analytics group and do other testing and analysis that identifies areas for us to inspect, audit or investigate. Second, most of our reports include meaningful recommendations that drive economy, efficiency, and effectiveness throughout VA programs and operations. Although we do not have authority to implement changes, we keep track of our open recommendations and the ones that are more than a year old are included in our Semi-Annual reports to the Secretary and Congress. Third, we promote accountability of VA employees if they fail to perform as expected. Individual accountability is something that we feel strongly about if it is deserved. Fourth, we treat whistleblowers and others who provide us with information with respect and dignity, and protect their identity if they desire. We rely heavily on information provided by whistleblowers, veterans, VA employees and others.

We need to treat people who provide us information with the proper courtesies to encourage them and others to provide us with information.

Values. We also established values that govern how we conduct ourselves professionally. Among other values, we are going to meet the highest standards of professionalism, character, ethics and integrity. We know that we judge how other people act. Therefore, we need to act beyond reproach for us to have the necessary credibility. Moreover, we look to continually improve our performance. I am a strong believer that the most effective organizations are those that recognize and embrace the need for continuous self-examination, change and improvement. We will accomplish this through investing in our workforce and reflecting on lessons learned to determine how we can improve so that we can do even better the next time.

OPERATIONAL ENHANCEMENTS

In the past 10 months, we have made, or are in the process of implementing, a number of other enhancements to the OIG's operation. Several of these initiatives represent concerted efforts by the OIG to focus on high-risk areas throughout VA with the goal of being more proactive in our oversight. I believe that these changes will enable us to perform more impactful work in a timelier manner.

Rapid Response Team. We established a Rapid Response Team to more consistently and timely respond to the highest-risk clinical allegations we receive concerning Veterans Health Administration (VHA) facilities or programs.

Access to Care Division. We also established an Access to Care Division that will conduct focused oversight audits and reviews designed to evaluate wait times and other barriers to receiving care in VHA.

Comprehensive Healthcare Inspection Program (CHIP). We have enhanced our healthcare inspection program, formerly known as the Combined Assessment Program (CAP), to make it more extensive and risk-based. Among other changes, we are placing greater attention on the effectiveness of leadership of individual medical centers and presenting a narrative of our findings.

Construction Oversight. We are in the process of establishing a division that will provide much needed oversight of VA's major construction projects.

Expanded Data Analytics and Proactive Measures. We have established a Data Analytics Council, which will collaborate across OIG directorates to leverage existing VA data sources to strategically identify impactful and proactive oversight initiatives, particularly in high-risk procurement and information technology (IT) programs and operations.

Coordination with Other Government Entities. We have increased our interactions with the Government Accountability Office and the Office of Special Counsel to ensure coordination and transparency of work.

FISCAL OUTLOOK

VA is the second largest Federal employer, operating the Nation's largest integrated health care system. For FY 2017, VA is operating under a $180 billion budget, with over 378,000 employees serving an estimated 21.3 million living veterans. More than 9 million veterans are actively enrolled in the VA health care system and almost 4.5 million veterans receive disability compensation.[2]

The VA OIG is a relatively small office compared to other Federal OIGs as a percentage of both the agency's full-time equivalent staffing and budget. The OIG is comprised of approximately 725 full-time employee equivalents (FTE) organized into five major directorates: Investigations, Audits and Evaluations, Healthcare Inspections, Contract Review, and Management and Administration.[3] About 225 employees are based in Washington, DC, while the remaining 500 are dispersed throughout our approximately 40 field offices nationwide. Since FY 2014, we have received approximately 39,000 contacts to our Hotline annually. Each year, we average about 350 reports and other work products, 475 arrests, 330 convictions, and $3.125 billion in monetary benefits for a return on investment of $30 for every $1 expended on OIG oversight.[4] This is a strong return and supplements the inestimable value we bring by helping VA improve its health care and benefits services that impact so many lives.

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[2] VA At-A-Glance Pocket Cards, Quarter 2, FY 2017. (Accessed February 28, 2017).
[3] The Office of Contract Review, with 27 employees, operates under a reimbursable agreement with VA's Office of Acquisition, Logistics, and Construction to provide reviews of vendors' proposals and contracts. Our remaining workforce is funded through appropriations.
[4] Based on the 5-year average of reports issued, arrests and fugitive felon arrests, convictions, total dollar impact, and return on investment as reported in OIG semiannual reports for FYs 2012, 2013, 2014, 2015, and 2016.

The VA OIG FY 2017 appropriation of $159.6 million—an increase of approximately $22 million over FY 2016—was the largest on record for the OIG and served as an acknowledgement by the previous Administration and Congress that the OIG could not meet the growing and sustained demand for oversight of vulnerable, high risk VA programs in the near term without a significant investment in organizational strength. This increase was intended to support deployment of approximately 100 additional full time positions. We crafted our FY 2017 budget request with the intention that it would be the first of several tiered increases to "right size" the OIG over the next several years. The expansion plan would increase FTE to 1,160 by FY 2021, and bring the VA OIG to a level on par with staffing and resources at VA and comparably situated OIGs.

In consideration of the hiring freeze and the Administration's anticipated efforts to scale back the size of the Federal government, which is discussed in greater detail in the section that follows, we reduced our FY 2018 requirements by $27 million compared to the $197 million figure submitted as part of our 3-year expansion plan last year. Our budget request for FY 2018 is $170 million, and coupled with anticipated FY 2017 carryover, will cover the costs of normal inflation assumptions and at least 100 additional FTE over FY 2017. The Administration is proposing to straight-line funding for FY 2018 at FY 2017 enacted levels for a number of VA discretionary programs. Under this scenario, OIG's FY 2018 budget would be $159.6 million—the same as FY 2017. This funding level overlooks potential inflation costs of at least $3 million for civilian pay raises and infrastructure. Although we do not project that OIG operations would be adversely impacted at this funding level for FY 2018 because of

available carryover funds, for subsequent years we would likely need to request a significant increase to the $159.6 million funding level to maintain current operations.

HIRING FREEZE IMPLICATIONS

We believe that the January 23, 2017 Presidential memorandum to freeze the hiring of Federal civilian employees, as well as the anticipated attrition plan to follow, will adversely affect the OIG's ability to recruit individuals for a number of the positions we need to fill. As a result, we expect to fall short of our original staffing target for FY 2017 and we will not be able to expand necessary resources. Guidance on the hiring freeze issued by the Office of Management and Budget (OMB) and the U.S. Office of Personnel Management (OPM) indicates that the Inspector General is the agency head for the purposes of determining which positions in the OIG are exempt from the freeze, as well as for the purposes of the agency-head review of job offers in the OIG that either do not have a start date or have a designated start date beyond February 22, 2017.[5] I have exempted several positions that are deemed necessary to meet "national security or public safety responsibilities," including essential activities to the extent that they protect life and property. These include positions that address patient safety and care, facility inspections, audits of programs with significant financial exposure, cybersecurity, and suspected criminal activity. In total, these exemptions account for approximately

[5] OMB/OPM Memorandum M-17-18, *Federal Civilian Hiring Freeze Guidance* (January 31, 2017). https://www.whitehouse.gov/sites/whitehouse.gov/files/images/M-17-18-Federal-Civilian-Hiring-Freeze.pdf.

50 percent of the vacancies that we intended to hire during FY 2017 based upon our appropriation and the projected attrition within our current workforce.[6]

The full impact of the hiring freeze remains unknown at this time. However, one foreseeable outcome is that it will limit the amount of work we can undertake due to the current number of vacancies within our organization. Furthermore, the freeze will negatively impact the OIG's ability to meet FY 2017 performance metrics, which were premised on an increase in staffing enabled by an increase in our budget. Although I made exemptions to the hiring freeze on a number of critical positions within the OIG based on OMB and OPM guidance, I did not exempt a number of open positions.

OVERSIGHT RESULTS

The OIG conducts strategic oversight of VA programs and operations in such areas as health care delivery, benefits processing, financial management, procurement practices, information management and security, and its workforce investment. Our work provides independent assessments of VA's operations and helps VA achieve its mission in critical areas while protecting the interests of veterans and taxpayers. Although we cannot accept all matters brought to our attention that appear to warrant some level of further review, it is important that we focus our efforts on mission-critical high risk areas we consider to be the most impactful work. When deciding whether to take on a matter, we consider a variety of factors, including but not limited to the scope of actual or

[6] Approximately 20 percent of all current OIG employees are eligible to retire through the end of calendar year 2017. By the end of calendar year 2020, that number will increase to nearly one-third of our workforce. These employees occupy positions throughout the OIG, to include healthcare and benefits inspectors, criminal investigators, auditors, Hotline analysts, and other support staff at both new and existing locations nationwide.

potential impact to veterans and/or taxpayers; whether there is imminent harm to VA patients or employees; the pervasiveness of the problem; whether we have conducted prior related oversight; and whether the issue should be handled by VA or another agency. Following is a selection of our work that demonstrates a clear and urgent need for expanded oversight of VA.

Veterans Health Administration

Providing timely and high quality health care to our nation's veterans is one of VA's key responsibilities. Historically, VHA has been a national leader in the quality of care provided to patients when compared with other major U.S. health care providers. However, in recent years, VHA has experienced significant challenges in delivering high-quality, timely health care—whether that care is provided within VHA or through VHA's ability to arrange for the delivery of services in the community. Factors such as increased demand, operational inefficiencies, and inadequate information systems to manage health care resources efficiently and effectively impact VHA's ability to ensure the quality and timeliness of the services it provides. In some cases, veterans do not receive the services they need. For more than a decade, the OIG and other organizations have issued numerous reports regarding issues with access to VA health care such as veteran wait times, scheduling practices, consult management, and the Non-VA care program. Since the nationwide scandal on patient wait times in 2014, we have continued to identify problems with VHA managing access to health care.

One of our most recent reports on the topic of health care access found that Veterans Integrated Service Network (VISN) 6 did not consistently provide timely access to health care for new patients at its VA medical facilities and through the Veterans Choice Program (Choice) in FY 2016.[7] It also did not have accurate wait time data. Our assessment of wait times for new patient appointments shows a significant difference when compared to wait time data captured in VHA's electronic scheduling system. As a result, we concluded that VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans were waiting for care. Among other consequences, the inaccurate wait time data resulted in a significant number of veterans not being eligible for treatment through Choice. VISN 6 also did not consistently manage the timeliness of specialty care consults. This audit demonstrates that many of the same access to care conditions reported over the last decade continued to exist within VISN 6 medical facilities in FY 2016.

Our work also noted opportunities for improving continuity of care between VHA and community care providers with respect to obtaining and scanning non-VA clinical records. Complete and accurate documentation in patient electronic health records (EHRs) is essential for sound, fully-informed clinical decision making. Gaps in non-VA documentation, such as those found during our review of a delay in care for a lung cancer patient, put patients at risk and make continuity of care between various

[7] *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6* (March 2, 2017). VISN 6 includes seven VA Medical Centers and over twenty-five Community Outpatient Clinics located in North Carolina and Virginia.

providers and specialties more difficult to achieve.[8] This review also discovered examples of consults[9] placed during the course of the patient's treatment with routine urgency even though the clinical expectation and actual need was for a more urgent response.

Our audit of VA's FY 2016 Consolidated Financial Statements also identified VHA's Community Care obligations, reconciliations, and accrued expenses as a material weakness. Lack of tools to estimate non-VA Care costs, lack of controls to ensure timely deobligations, and the difficulty in reconciling non-VA Care authorizations to obligations in VA's Financial Management System, make the accurate and timely management of purchased care funds challenging. In addition, VHA's Office of Community Care (OCC) did not have adequate policies and procedures for its own monitoring activities. OCC's activities also were not integrated with VA and VHA Chief Financial Officer (CFO) responsibilities under P.L. 101-576, the *Chief Financial Officers Act of 1990*, to develop and maintain integrated accounting and financial management systems and provide policy guidance and oversight of all Community Care financial management personnel, activities, and operations.

To address the difficulties in estimating the costs of non-VA provider care, VA has requested legislation that would allow VA to record an obligation at the time of payment

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[8] *Healthcare Inspection, Delay in Care of a Lung Cancer Patient Phoenix VA Health Care System Phoenix, Arizona* (September 30, 2016).

[9] VHA policy states that consults are a mechanism for physicians and other health care providers to create templated notes to request an opinion, advice, or expertise regarding evaluation or management of specific problems in the care of individual patients. There are certain timeliness standards for completing consults based on three urgency designations: routine, urgent, and STAT.

rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone—i.e., obligating funds at the time of payment—would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls to monitor accounting, reconciliation, and management information processes to ensure they effectively manage funds appropriated by Congress.

We have issued a number of reports since 2013 that evaluated consult timeliness and the impact of consult delays on patient outcomes. For example, our recent review into alleged consult delays and management concerns at the VA Montana Healthcare System (VA Montana), Fort Harrison, Montana, found that a large percentage (between 42 and 61 percent) of patients with consults ordered in FY 2015 experienced a delay in obtaining a clinical in-house consult, non-VA care consult, and/or Choice consult.[10] We found that delays among consults ordered in FY 2015 may have harmed four patients. Beginning in July 2015, the system initiated a focused effort to identify and resolve factors that contributed to consult delays and reduce outstanding consults. Despite this effort, we found evidence of persistent issues with completing consults timely in FY 2016 (through late August 2016). Efforts are ongoing to address those factors within the VA Montana Healthcare System's control that contribute to consult delays, including hiring additional staff to process non-VA care and Choice consults and reducing the

[10] *Healthcare Inspection, Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana* (March 10, 2017).

number of unnecessary consults. We made two recommendations to the VA Montana Director to ensure that an external (non-system) source review the care of patients we identified who were potentially harmed by consult delays and that VA staff provide institutional disclosures, as appropriate. We also made a recommendation regarding ongoing efforts to improve consult timeliness. VA Montana's Director and the VISN 19 Director concurred with our three recommendations and provided a responsive action plan and milestones to address the recommendations.

Adequate staffing is essential to providing timely health care access to patients. As required by Public Law (P.L.) 113-146, the *Veterans Access, Choice, and Accountability Act of 2014,* we have completed the third of five required determinations of staffing shortages in VHA.[11] We determined that the top five critical need occupations for FY 2016 are Medical Officer, Nurse, Psychologist, Physician Assistant, Physical Therapist, and Medical Technologist. Because of a tie for fifth place, we had six occupations in our determination. In looking at the gains, losses, and changes in onboard staffing for critical need occupations, we found that in the past year, VHA continued to increase the absolute number of staff in critical need occupations. However the net gains are still significantly reduced by high loss rates. We noted in our prior reports that because of the relatively long onboarding process and challenges in finding suitable candidates, staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and FTE allocation at the individual facility level. Well-developed predictive staffing models

[11] *Healthcare Inspection, OIG Determination of VHA Occupational Staffing Shortages* (September 28, 2016).

would allow VHA to better assess and implement effective measures to address the above concerns. In our initial (January 30, 2015) determination, we recommended that VHA continue to develop and implement staffing plans for critical need occupations. In the second report, we found VHA was in the early stages of developing staffing models. In this third report, we found that VHA had developed draft reports on staffing models for certain medical specialties and regrettable losses. While VHA had made progress in developing and implementing staffing models, we did not identify a plan that included a set of milestones and timelines for further staffing model development to achieve full implementation. We made four recommendations, two of which are repeat recommendations, to address this finding.

While filling these critical staffing shortages is essential to patient care, VA, and in particular VHA, must remain cognizant of the need to strategically and prudently use taxpayer dollars in the recruitment and retention of highly qualified employees in hard-to-fill positions. Our recent report of VA's use of recruitment, relocation, and retention (3R) incentives found that VA needs to improve controls over its use of these pay authorities to ensure they are applied strategically and prudently.[12] VHA accounted for at least 99 percent of VA's 3R incentive spending in FYs 2012 through 2015. We identified ineffective oversight processes to ensure compliance with VA's 3R incentive requirements, inadequate oversight of how 3R incentives are used to address known and expected workforce gaps, and ineffective procedures to recoup funds from individuals with outstanding recruitment and relocation incentive service obligations. As a result, VA has limited assurance that it is using 3R incentives effectively and

[12] *Audit of Recruitment, Relocation, and Retention Incentives* (January 5, 2017).

strategically to acquire and retain talent, yet these tools are vital to VHA's success for recruiting and retaining qualified staff. Considering that VA anticipates about 31 percent of its employees will be eligible for retirement by 2020, including about 58 percent of the SES workforce, it is imperative that VA take timely action to ensure its use of 3R incentives aligns with its immediate and long-term human capital goals. Without stronger internal controls, we projected that VA risks an estimated $158.7 million in unsupported 3R incentive spending, in addition to about $3.9 million in estimated repayment liabilities projected for FYs 2015 through 2019.

The OIG routinely investigates and arrests individuals who steal and/or sell controlled and non-controlled substances from and at VA facilities. During FY 2016, we opened 49 investigations resulting in 55 individuals being charged with various crimes relating to illicit drug activity. Among them were VA health care providers who stole pain medications intended for specific patients and consumed them while on-duty and delivering patient care; employees who diverted or stole pharmaceuticals for the purpose of illegal sale; employees of non-VA delivery services who stole prescription drugs intended for VA patients; patients who sold their prescribed drugs to other VA patients; and individuals who sold contraband drugs such as heroin at VA facilities. As a result of one such investigation, a former Murfreesboro, Tennessee, VA Medical Center (VAMC) nurse was arrested after being indicted for obtaining a controlled substance by fraud and theft of property. That OIG investigation revealed that on at least 18 occasions between April 2014 and March 2015, the defendant diverted oxycodone, hydrocodone, morphine, and lorazepam intended for Community Living

Center geriatric patients. The defendant admitted to stealing the drugs for personal use and subsequently resigned from her position at VA. In another example, an investigation at the Little Rock, Arkansas, VAMC led to two pharmacy technicians and a pharmacy technician student trainee being indicted for charges to include conspiracy, theft, and possession with intent to distribute. The OIG investigation resulted in the defendants being charged with diverting and distributing 4,000 oxycodone tablets, 3,300 hydrocodone tablets, 308 ounces of promethazine with codeine syrup, and over 14,000 Viagra and Cialis tablets. Three additional VA employees were identified as part of the drug diversion, resulting in a resignation and reassignments. The monetary loss to VA was over $77,000.[13] Drug theft is a serious issue that the OIG will continue to pursue diligently. Not only is it illegal, it is an issue of patient safety if the provider is ingesting controlled substances while on duty, if false entries are placed in patient files to cover up the diversion, or if patients are given another substance in place of the diverted drug.

Veterans Benefits Administration

Delivering timely and accurate benefits is central to VA's mission. The Veterans Benefits Administration (VBA) is responsible for oversight of the nationwide network of VA Regional Offices (VARO) that administer a range of veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. These programs are estimated to

[13] *Veterans Affairs Employees Charged with Stealing and Selling Prescription Drugs*. Department of Justice, U.S. Attorney's Office, Eastern District of Arkansas (February 8, 2017).

pay out over $104 billion in mandatory benefit programs to veterans and their beneficiaries in FY 2017.[14]

While we have continuously reported the need for enhanced policies and procedures, training, oversight, quality reviews, and other management controls to improve the timeliness and accuracy of claims decisions, we also remain concerned that VBA's aggressive focus on reducing the backlog of compensation claims occurred at the expense of delaying the processing of other VBA workload such as its non-rating and appealed claims workload. For example, our June 2016 audit found that VBA staff did not consistently take action to adjust compensation and pension benefits for incarcerated veterans, which resulted in improper payments valued at approximately $104.1 million.[15] Without improvements, we estimated VBA could make additional improper benefits payments totaling about $203.8 million from FY 2016 through FY 2020. In general, VBA did not place priority on processing incarceration adjustments because VBA did not consider these non-rating claims to be part of the disability claims backlog. Both VBA Central Office and VARO staff consistently reported that incarceration adjustments were not a high priority. As a result of our work, VBA agreed to increase the priority of processing its incarceration adjustment workload.

In another example, in September 2016, we reported that veterans entitled to statutory housebound benefits did not consistently receive correct benefits decisions because VBA staff overlooked the issue, and VBA's electronic reminder was ineffective. Based

[14] VA's FY 2017 Budget Submission in Brief.
[15] *Audit of Compensation and Pension Benefit Payments to Incarcerated Veterans* (June 28, 2016)

on our sample projections, we estimated that these errors resulted in some veterans being underpaid $110.1 million while others were overpaid $44.3 million. As a result of our work, VBA will conduct annual reviews of housebound benefits and tighten controls over this program and we are providing increased oversight of this issue as part of our FY 2017 benefits inspection program.

Our work has also identified improper payments with respect to Post-9/11 G.I. Bill education benefits. Our September 2016 audit projected that, of the more than $5.2 billion in payments made in academic year 2013-2014, VBA made about $247.6 million in improper payments and $205.5 million in missed recoupments annually.[16] As a result, VBA may have an estimated $2.3 billion in improper tuition and fee payments and missed recoupments over the next five academic school years if it does not strengthen program controls. To help reduce improper payments and missed recoupments, VBA needs to:

- Improve the School Certifying Officials' awareness of program requirements related to the submission of accurate and complete enrollment certifications;
- Refine the school selection process and ensure the completion of required compliance surveys to improve the verification and monitoring of tuition and fee certifications;
- Develop adequate guidance regarding allowable book fees and repeated classes; and

[16] *Audit of Post-9/11 G.I. Bill Tuition and Fee Payments* (September 30, 2016)

- Verify and obtain supporting documentation for mitigating circumstances.

Our work also uncovered fraud schemes related to education benefits. For example, a husband and wife who co-owned a beauty school in Chesapeake, Virginia, pled guilty to fraud and related charges after an investigation determined that they provided information to VBA falsely representing that they provided full-time schooling to hundreds of veteran students.[17] In reality, the school was a sham. Most veterans enrolled in courses received few, if any, hours of instruction, and there were no tests, exams, or practical exercises given. Rather, students were directed to simply sign in and out of the school each day so that the owners could report to VBA that they were enrolled and attending. In exchange, the owners received Post-9/11 GI Bill tuition payments for each veteran totaling more than $4.5 million between October 2011 and September 2016. The husband and wife were each sentenced to 5 years' imprisonment and community service.

Financial Management

The OIG has repeatedly reported on VA's legacy systems and how they impair VA operations. A key element to accurate planning is a financial system that provides timely information to VA leadership. As was reported in *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015*, VA's complex, disjointed, and legacy financial management system architecture has continued to deteriorate over time and no longer meets the increasingly stringent and demanding financial management and

[17] *Owner of Chesapeake Barber College Pleads Guilty to $4.5 Million GI Bill Fraud.* Department of Justice, U.S. Attorney's Office, Eastern District of Virginia (December 14, 2016).

reporting requirements mandated by the Department of the Treasury and OMB.[18] VA continues to be challenged in its efforts to apply consistent and proactive enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems. VA announced in October 2016 that it had selected the Department of Agriculture as its Federal shared service provider to deliver a modern financial management solution to replace its existing core financial management system. When completed, this system replacement will be a major advancement for VA in modernizing its system architecture for improved financial management and stewardship.

VA struggles with improper payments, including accurately reporting on them as well as working to eliminate them. Our work on VA's compliance with the Improper Payments Elimination and Recovery Act (IPERA) for FY 2016 continues. However, we reported in May 2016 that VA did not fully comply with IPERA for FY 2015. Two programs exceeded the improper payment threshold of 10 percent—VHA Community Care and Purchased Long Term Care Support and Services. Eight programs, including those two programs, also did not meet reduction targets. More important, OMB designated the VHA Community Care, Purchased Long Term Services and Support, and Compensation programs as high-priority in November 2015. For high-priority programs, agencies must establish semi-annual or quarterly actions for reducing improper payments, as required by the Improper Payment Elimination and Recovery Improvement Act of 2012 (IPERIA) and OMB Circular A-123, Appendix C.

[18] *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015* (November 15, 2016).

Procurement

For several years, OIG audits and reviews have identified systemic deficiencies in all phases of the procurement process, including planning, solicitation, negotiation, award, and administration. We attribute these deficiencies largely to inadequate oversight and accountability. The replacement of the Denver VAMC is an extremely costly example of the result of inadequate oversight.[19] We confirmed the project to build a new medical center in the Denver area has experienced significant and unnecessary cost overruns and schedule slippages. Originally estimated for 2013 completion, it will not be ready before mid-to-late 2018, about 20 years after its need was identified in the late 1990s. Through all phases of the project, we identified various factors that significantly contributed to delays and rising costs, including:

- Inadequate planning and design,
- Initiation of the construction phase without adequate design plans,
- Changing the acquisition strategy mid-stream, and
- Untimely change request processing.

This occurred due to a series of poor business decisions and mismanagement by VA senior officials. Our report summarizes the significant management decisions and factors that resulted in a project years behind schedule and costing more than twice the initial budget of $800 million. We made five recommendations and VA management concurred with all recommendations. We recently requested information from VA on

[19] *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System* (September 21, 2016).

the implementation status of the recommendations and will keep them open until VA provides satisfactory evidence of implementation.

Lack of sufficient oversight also increases the risk that VA will award sole source and set-aside contracts intended for eligible Veteran-Owned and Service-Disabled Veteran-Owned Small Businesses (VOSB and SDVOSB) to ineligible parties and that contractual performance requirements will not be met. The VOSB and SDVOSB contracting programs increase contracting and subcontracting opportunities for veterans and service-disabled veterans and ensure these businesses receive fair consideration when VA purchases goods and services. However, the program's set-aside advantage makes it a target of abuse and fraud by ineligible contractors using various deceptive schemes to acquire lucrative VA contracts.

Many of our investigations involve "pass-through" schemes whereby the VOSB or SDVOSB win a contract, perform little to none of the work, and passes through the contract or large portions of the contract to the ineligible company for a fee or percentage of the award. The VOSB or SDVOSB simply functions as a shell business and "passes through" the work to the ineligible business. This defeats the socio-economic goals that were intended under the set-aside program. Similarly, "Rent-A-Vet" schemes occur when an otherwise ineligible business uses a veteran as a front to try to establish VOSB or SDVOSB eligibility. In this scheme, the true owner of a company conspires with a veteran to have the veteran assume ownership of the company, but in name only. The true owner maintains control over the company, and

the veteran receives either a flat fee or a percentage of any contracts awarded and does not perform any functions associated with owning or operating the company. A variation of this scheme involves the establishment of a new firm for the sole purpose of set-aside acquisition. The new firm is not actively managed or controlled by the veteran, who acts only as a figurehead.

For example, a non-veteran owner of a purported SDVOSB was sentenced to 30 months' incarceration, 12 months' supervised release, and was ordered to pay a $1 million fine after previously being found guilty of fraud charges stemming from an investigation that revealed the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two service-disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. As a result of the defendant's false representations to Federal contracting officers that the company was owned and operated by those service-disabled veterans, the company was awarded more than $112 million in Federal contracts between 2006 and November 2010, of which $110 million were VA contracts. The case involved over 200 VA construction contracts that occurred in at least 7 states. Of note, prosecutions of this type were rare until the VA OIG started championing this type of fraud case to the Department of Justice. Through this collaboration, we have been successful in obtaining many convictions. Although these types of investigations are resource intensive, our work helps ensure that SDVOSBs and VOSBs can compete for business.

Information Technology

Further, the OIG has frequently identified examples where VA has struggled to design, procure, and/or implement functional IT systems. Further, for the past 17 years, IT security has been reported as a material weakness in the Consolidated Financial Statement audits that are conducted annually by the OIG's contracted independent auditors, CliftonLarsonAllen.[20]

VA has a high number of legacy systems needing replacement: the Financial Management System; Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system; Veterans Health Information Systems and Technology Architecture, and the Benefits Delivery Network. After years of effort focused on replacement of VA's legacy scheduling software, a new scheduling system is still not in place. VA's issues with scheduling appointments are related to the inability to define its requirements and determine if a commercial solution is available or if it must design a system. Replacing systems has been a major challenge across the government and is not unique to VA. We have issued a number of reports outlining access issues and our work in this area is continuing.

While the difficulties between VA's EHR and the Department of Defense's EHR are well documented, the increased utilization of care in the community will present further IT challenges. To ensure that medical providers both inside and outside VA have the most complete and up-to-date information, VA needs to find a more effective method for sharing patients' EHRs.

[20] *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015* (November 15, 2016).

While OIG's audit of VA's information security program for FY 2015 noted some improvements, we continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems.[21] Weaknesses in access and configuration management controls resulted from VA not fully implementing security standards on all servers, databases, and network devices. VA also has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, databases, and server platforms VA-wide. Further our in-process audit work for FY 2016 has found VA has not remediated over 7,000 outstanding system security risks in its corresponding Plans of Action and Milestones, the control designed to improve its information security posture.

RECOMMENDATION FOLLOW-UP

Follow-up is an important component of OIG oversight work. OMB requires a process to follow up and report on the status of OIG report recommendations. The OIG is also required to report in its Semiannual Report to Congress on the status of report recommendations, with an added emphasis on those recommendations pending over 1 year. As of the conclusion of February 2017, there were 138 total open reports and 448 total open recommendations. 65 (47 percent) of these reports and 154 (34 percent) of these recommendations are greater than 1 year old.

[21] *Federal Information Security Modernization Act Audit for Fiscal Year 2015* (March 15, 2016).

OIG staff take great care in developing recommendations for improvement that are clear and specific, provide a yardstick to measure improvement and gauge full implementation. We develop recommendations for corrective action that can be realistically implemented within a year. As such, the OIG generally does not accept VA implementation plans that take more than a year to complete, except under the rarest of circumstances and only when measurable timelines are provided. Over the last year, approximately 80 percent of recommendations have been closed within 1 year.

CONCLUSION

VA is a massive and decentralized enterprise with significant vulnerabilities to fraud, waste, abuse, and mismanagement in its programs and operations; the consequences of which can have a dramatic effect on veterans and taxpayers. Regardless of hiring restrictions, the OIG must be positioned to provide effective oversight especially in the high-risk areas related to patient care provided by VA and community providers. With continued support from Congress, we look forward to increasing our ability to conduct impactful oversight of VA programs and operations for the betterment of our veterans, their families, and American taxpayers.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.

OIG MISSION

To serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs (VA) through independent audits, inspections, and investigations.

VISION

To meet our mission and enhance the trust and confidence of veterans and their families, Veterans Service Organizations, Congress, VA employees, and the public, we must:

- Ensure that our work is independent and avoid any appearance of impairment to our independence.
- Prevent and detect fraud, waste, and abuse in VA programs and operations.
- Be proactive and strategic in identifying impactful issues.
- Produce reports that are:
  - Accurate
  - Timely
  - Fair
  - Objective
  - Thorough
- Make meaningful recommendations that drive economy, efficiency, and effectiveness throughout VA programs and operations.
- Be fully transparent by promptly releasing reports that are not otherwise prohibited from disclosure.
- Promote accountability of VA employees if they fail to perform as expected.
- Attract, develop, and retain the highest quality staff in the Office of Inspector General (OIG).
- Treat whistleblowers and others who provide information to the OIG with respect and dignity and protect their identities if they so desire.

VALUES

Our conduct will be guided and informed by adherence to the following values:

- Meet the highest standards of professionalism, character, ethics, and integrity.
- Work as one organization by encouraging teamwork and collaboration across directorates and offices.
- Establish a positive and engaging work environment.
- Promote diversity, individual perspectives, and equal opportunity throughout the OIG.
- Respect the role and expertise that each staff member brings to the OIG.
- Continually improve our performance.
- Ensure equitable opportunities for professional growth and development.
- Accept responsibility for our behavior and performance.

Mr. DENT. Thank you very much, Mr. Missal, for your testimony.

PROBLEMS WITH SUICIDE HOTLINE

Last year, the IG issued a report that was fairly damning in its critique of the operations of the Veterans Crisis Line, the suicide hotline, VA's major tool to prevent veteran suicide. At that time, VA countered that the IG report was using old data and the agency had made improvements to its operation, adding substantially more funding, installing new leadership.

But the followup IG report issued on Monday suggests that the VA is still having significant problems with the suicide hotline. The new leadership has already left; the secondary site in Atlanta is understaffed; clinical guidelines are not being transmitted; quality-control measures are not being implemented; and staff lack training.

Do you think the VA has made any progress in improving the performance of the hotline since last year?

Mr. MISSAL. We took a look at the hotline and did our review beginning in June of 2016. I would note that there were seven outstanding recommendations that were still open from our February 2016 report. They were scheduled to be completed, according to VA's plan, by September of 2016. Those 7 recommendations from our last report remain open, as well as the additional 16 that we had here.

So I guess I would say that there are still many significant issues that we found with respect to the VCL.

Mr. DENT. Members of Congress were very concerned last year, so we included language in the bill requiring the VA to maintain suicide hotline standards consistent with the guidelines of the American Association of Suicidology.

POSSIBLE VIOLATION OF APPROPRIATIONS LAW

At that time, VA had assured us that the hotline met those guidelines. And with your new report findings, do you think that the VA is in violation of our appropriations law?

Mr. MISSAL. I don't know if I can make that assessment. We didn't look at it quite that way. We identified a number of the shortcomings in the training, in governance, in staffing, in leadership, et cetera. And so I think we did raise some significant issues.

IMPROVEMENTS IN SCHEDULING DELAYS

Mr. DENT. There are some audits showing continued medical appointment scheduling delays that I wanted to discuss.

Over the last 2 years, the IG has had the enormous job of auditing all the VA medical centers about allegations of scheduling delays and malfeasance. We understand that you have revisited some regions and have found that problems have been resolved in some areas but not in some others.

What are the factors that have been key to improvements in some of these regions, if you could share that with us?

Mr. MISSAL. I think, one thing I have found in the 10 months since I have been here is the importance of leadership at various levels. VA health care is a very decentralized operation, and what

is pretty clear when you go to either medical centers or the VISNs, the regions that they have divided the country into, the leadership at those areas are really critically important to the performance of either the medical center or the VISN.

VA'S ANTIQUATED FINANCIAL MANAGEMENT SYSTEM

Mr. DENT. I would like to now move to the VA's antiquated financial management system. Your reviews of nine VA care programs revealed a morass of problems in financial accounting, timely payment to providers, and inadequate internal controls. A significant share of these problems seems to be associated with the antiquated financial management system VA continues to use after its previous efforts to replace it had failed.

Do you think the VA's selection of the Department of Agriculture as its Federal shared service provider to deliver a modern financial management system will work for the VA where prior attempts for new systems have failed?

Mr. MISSAL. That is something we are going to look at very closely. They had a number of material weaknesses and significant deficiencies in their financial statements this past year, which was an increase over the previous year. They made the commitment that they are going to go with a shared service model, and we will test it and see if it has any improvements.

SHIFT TO COMMERCIAL/IT SOFTWARE

Mr. DENT. Okay.

And I would also like to just briefly mention the VA shift to commercial IT software for the health record. Secretary Shulkin has announced that he believes the VA should use commercially developed information technology software rather than continuing to build it in-house.

From the OIG's review of VA IT, do you think this is the appropriate path for the VA to take? And with its current skill set, is VA capable of procuring IT and managing contracts sufficiently and diligently?

Mr. MISSAL. IT has been a significant problem that we have identified in various programs and operations at VA. I heard the Secretary make that commitment, statement that he was going to go forward, and I think it remains to be seen whether or not that will be successful.

RISK OF PURCHASE OF COMMERCIAL/IT SYSTEMS

Mr. DENT. And can you just quickly elaborate on any risks? What are the risks that you see with the purchase of commercial IT systems for a healthcare system as enormous as the VA's? And how can the VA mitigate those risks?

Mr. MISSAL. I think it is integrating those systems into VA. VA has a number of different IT systems and they need to make sure that they all work together. They have to make sure that they have the proper staffing, the proper training, and the proper funding to get it done.

Mr. DENT. Thank you.

At this time, I would recognize the ranking member, Ms. Wasserman Schultz, for 5 minutes.

CHALLENGES OF VETERANS CRISIS LINE ROLLOVER CALLS

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

Mr. Missal, I want to continue the chairman's line of questioning on the Veterans Crisis Line.

You released a report on Monday——

Mr. MISSAL. Correct.

Ms. WASSERMAN SCHULTZ. This report addressed the challenges that the Veterans Crisis Line was experiencing, particularly with rollover calls to the backup call center. And that was in spite of adding the Atlanta call center, a second call center. There were significant percentages of rollovers, which is why I find it baffling that, a day later, the VA releases, you know, a statement saying that they have addressed it and that now their rollover is 1 percent.

That seemed completely incongruous with your report and nearly impossible for it to have been resolved in 24 hours. So can you address that pretty significant discrepancy and whether you think that the VA has addressed the problems in the report?

Additionally, when we were at the D.C. VA Medical Center the other day, it seemed very clear, to all of us that there is not uniform training across the board between local medical centers and the national Crisis Line training. And that also seems to be causing problems for veterans who are in dire need and could risk life. And, in fact, there has been life lost due to lack of training.

Mr. MISSAL. Sure.

Okay. With respect to the rollover calls, our inspection period covered the middle of June to the middle of December 2016. So we had the most recent data. I believe our last month was November of 2016. So we listed in our report all those numbers.

The Atlanta operation was brought about to try to, among other things, limit the dependency on these backup centers. They started bringing it up in stages, beginning in the fall. As of the middle of December, it still was not fully operational.

So we have not looked at it since that time, in the 3½ months or so since then. So I really can't comment whether or not their numbers are 1 percent or some other number.

Ms. WASSERMAN SCHULTZ. I think you can understand the doubt that I feel, given that the VA has already had a problem with fudging and altering data to reflect better numbers than reality.

So do you have plans to follow up and actually take another look at the last few months so that you can confirm these numbers? Because it is hard to have confidence in these numbers, given their track record.

Mr. MISSAL. Yes. There are 7 outstanding recommendations from our February 2016 report, 16 open from our current report. We consider both of those reports still open until we get satisfaction that they have met their commitments to complete those recommendations. So we will continue to look at the VCL, at a minimum, until those recommendations are fulfilled.

CHOICE PROGRAM

Ms. WASSERMAN SCHULTZ. Thank you. Because there are literally lives at stake from getting it wrong.

In my remaining minute and a half, I just want to ask you about the Choice Program. Your report found that veterans are still waiting months for appointments made through the Choice Program.

I just went to my own Miami VA Medical Center, and they gave me a very glowing picture of how much the wait times have been reduced. But, according to your report, veterans covered by Health Net, which is where the Miami VA is, on average, waited 84 days to get an appointment—42 days for the authorizations to be provided and then another 42 days for the appointment to be scheduled and the service provided.

So, first, why is it taking the VA 42 days to provide authorization? And why is it taking Health Net 42 more days after the authorization?

Mr. MISSAL. Right. The numbers you are talking about relate to our report on VISN 6. What we had previously done is we had looked at a specific facility. What we decided to do is look more broadly. VISN 6 governs VA facilities in the Virginia and North Carolina.

And the reason it took as long as it did was there was a lot of administrative issues involved in doing that. There was confusion. The rules for Choice are very complex, for example, who is eligible to qualify.

And so the funding for Choice is expiring in the middle of August of this year. One of the things I think needs to be done is to make it as uncomplicated as possible so that it is easier to sign people up, that veterans know exactly what their options are, and that the third-party administrators can move people through the system more quickly.

Ms. WASSERMAN SCHULTZ. Thank you.

I yield back.

Mr. DENT. Mr. Jenkins is recognized for 5 minutes.

Mr. JENKINS. Thank you.

AIR QUALITY ENVIRONMENTAL CONCERNS

Good morning, and welcome.

The community outpatient clinic in Greenbrier County, as you well know, several years ago had complaints of air quality environmental concerns, both from employees and our veterans who were seeking care and treatment there. A report was issued by the OIG, and we had to go to bat to make sure that that CBOC continued, in a new location, in Greenbrier County.

But can you go back, the status of your findings from that 2015 report—what actions has OIG done with regard to that report? Which I believe you all did find environmental air quality concerns at that CBOC in Greenbrier County.

Mr. MISSAL. Right. We did note ongoing air quality issues in that CBOC in 2015. It was closed as you know. It was the VA's responsibility to fix it. We have not been back since then to look at it, but we are well aware that these are commitments they made, and they need to follow through on those.

Mr. JENKINS. Well, that facility is closed. It is not being used. There is a new CBOC facility. So the old issues are going to be at that old facility; we are not there anymore.

But the OIG, obviously, hopefully, takes these issues of complaints from patients, our veterans, and employees seriously on environmental air quality. So one of my interests is followup activities after that report has been issued.

Mr. MISSAL. Yes. I would say that we have a very active healthcare inspection program, where we get around to the medical centers, some of the CBOCs as well. And environment of care is one of the areas we look at very carefully. So for every facility we go in, we check the environment of care for issues just as you raised.

STATE PRESCRIPTION DRUG MONITORING PROGRAMS

Mr. JENKINS. Second, under care of the addiction recovery relating to opioid abuse/misuse, there is a real emphasis, and it was in that legislation, asking the VA to start appropriately sharing the prescription information to State prescription monitoring programs, PDMPs. It is referred to in a lot of different ways. Most every State has one up and running.

What is the OIG doing to ensure appropriate information-sharing from the prescription issuance on the veterans side, getting into State PDMPs so we make sure we enhance the quality of care, and also make sure we are avoiding diversion and not adding to the drug crisis, and opioid diversion problem?

Mr. MISSAL. Right. Opioid misuse and other controlled substance misuse is a very great concern to us, and we have a very active program in this area.

With respect to the PDMPs, we do have access to those. It is VA that can enter data. We can, though, see it, and we do use it on occasion in our work.

With respect to opioid misuse/abuse and, actually, the stealing of opioids and other controlled substances, we have a number of investigations going on currently, and we have brought a number of cases recently which have resulted in jail time and other sanctions against individuals.

Mr. JENKINS. Well, I understand a doctor at a VA will have access. They are an authorized recipient of data. They can tap in and look at the prescribing history.

My question is, under CARA's direction to the VA, to have the VA actually submit information to State PDMPs, what is the VA doing about complying with that expectation?

Mr. MISSAL. We haven't looked specifically at that. Given how decentralized it is, it is really going to be facility by facility to see whether or not they are complying with the rules. But that is something we are considering looking at more closely, because we agree, it is a major concern.

Mr. JENKINS. Well, Bob McDonald, the previous VA Secretary, he said publicly multiple times the VA is going to start submitting their prescribing data to PDMPs. So I would encourage you—I appreciate your statement of, we are going to be looking into this. I think this is a priority issue, with an opioid crisis in so many parts of this country. I would hope you would move it from a "we intend

to look into it," because I do believe now there is actually a congressional mandate relating to the VA. And I think the OIG plays a key role in making sure that the VA fulfills its statutory obligation.

This is back to this life-and-death issue, and we have to have better information systems. The VA has a responsibility, and I hope you will make sure the VA lives up to that responsibility.

Mr. MISSAL. Yes, sir. We share your concern, absolutely.

Mr. JENKINS. Thank you.

I yield back.

Mr. DENT. Thank you, Mr. Jenkins.

At this time, I would like to recognize the former ranking member of the subcommittee, Mr. Bishop, for 5 minutes.

Mr. BISHOP. Thank you, Mr. Chairman.

Welcome, again, to our distinguished IG.

VA INFORMATION SYSTEMS VULNERABILITIES

It is critical that we put measures in place to protect sensitive information and to defend against those who would seek to gain unauthorized access to that information. The VA has an obligation to safeguard the data that we hold on veterans, and I know that everybody takes that responsibility seriously.

In your statement, aspects of the VA IT security have been continually reported, you indicate, as material weaknesses for some 17 years.

Mr. MISSAL. Correct.

Mr. BISHOP. From my understanding, in the latest information security information audit, you recommended 35 actions that would improve the information security program.

How many of those have been implemented? And what is your current assessment of the VA's vulnerability against cyber attack and ability to respond effectively to a successful attack?

Mr. MISSAL. I don't have the precise information of how many of those recommendations they have implemented. We have talked to them frequently about this issue.

We are just now starting our work for this year on cybersecurity and IT security, and we are going to be very aggressive in looking at it. And to the extent there are issues that we see as we are going through the audit, we will raise it again with them. We consider this very important, and hopefully they will make progress.

Mr. BISHOP. Can you submit that information to us in writing at a later date?

Mr. MISSAL. Sure. Happy to do so.

[The information follows:]

In the OIG's FISMA report for FY 2015, we made 35 recommendations. During our work for FISMA in FY 2016, we closed five of the 35 recommendations from FY 2015. However, for FY 2016, we added three additional recommendations so we have a total of 33 open recommendations related to FISMA. We also perform other IT security related work and currently recommendations remain open in two other reports:

"Review of Alleged Transmission of Sensitive VA Data Over Internet Connections"—Issued on March 6, 2013—Recommendation 1 remains open.

"Review of Unauthorized System Interconnection at the VA Regional Office in Wichita, Kansas"—Issued on April 6, 2017—Recommendations 2, 4, and 6 remain open.

Mr. BISHOP. Thank you.

PROCUREMENT DEFICIENCIES

In your statement, you noted that the VA has systemic deficiencies in all phases of its procurement process. From your assessment, is it that the VA does not have the proper policies and procedures in place, or is it that they are not performing in accordance with the procurement standards? Or is it both?

Mr. MISSAL. Procurement is an area that we feel is one of our priorities, because of the amount of taxpayer dollars at issue here. And what we have found is both. We have found both policies and procedures that are not up to what we would expect, and we have also found situations where they haven't followed the policies and procedures as well.

COLLECTING RACE AND ETHNICITY DATA

Mr. BISHOP. On another subject, after reviewing the 2016 Advisory Committee Report on Minority Veterans, I am concerned the VA doesn't consistently collect race and ethnicity data.

According to the Center for Minority Veterans, by 2040, minority veterans are projected to represent over a third of all of the veterans, despite the overall veteran population decreases. This is information that could be used to suggest policy reforms and recommendations to address the needs of an increasing minority veteran population, to include health disparities, academic affiliations, unconscious bias in hiring practices that may lead to a lack of diversity and specifically at the senior management level.

Do you have any planned or any recent audits, inspections, or evaluations that focus on minority veterans and on women veterans? And if so, what are some of the recommendations, and how many of those remain open?

Mr. MISSAL. We don't currently have anything on minority veterans.

On women veterans, we are doing a national healthcare inspection to see the treatment of women veterans and how VA accommodates women veterans. That should be released shortly.

I recognize the importance of all the issues you raise. And that is something, as we are looking at our workload going forward, it is something we will consider.

Mr. BISHOP. How can we make sure that the VA collects data on race and ethnicity so that we will have the data from which to make assessments?

Mr. MISSAL. I am not aware of what process they have in place and what they are doing in that area to know. But, obviously, they should have policies and procedures for any program that they have. And that would be something, if we looked at that, we would focus in on the policies and procedures and how they are implementing those policies and procedures.

Mr. BISHOP. I was told that the VA does not collect data on ethnicity. So, for example, I couldn't ask you how many black veterans you have or how many Hispanic veterans you have or how many Asian veterans you have, because the VA doesn't collect that kind of data.

And what I am suggesting is that we need to collect data in those categories. This data would assist you in your audits; it would assist us in our oversight. But we don't have that information. Perhaps you can make recommendations on what we need to do to get that information or if we can just ask for it.

Mr. MISSAL. Sure. We can look into that, certainly.

Mr. BISHOP. Thank you.

My time has expired.

Mr. DENT. Mr. Valadao.

Mr. VALADAO. Thank you.

Thank you again for taking some time today. And I know we are hitting on the wait times quite a bit, but I do want to follow up on that a little bit.

PATIENT WAIT TIMES

The VA publishes a bimonthly patient access report for all VA medical centers and community-based outpatient clinics, which include information such as average wait times for veterans enrolled in the Veterans Health Administration.

Currently, the VA medical center in Fresno, California, represents an average wait time of 12 days to see a specialist. However, I am hearing from constituents of mine all the time who report waiting a couple of months or more to get in to see the doctor. While I understand that 12 days is the average wait time, there is a big difference between 12 days and 2 months.

In your experience, do you believe the average wait time data in the bimonthly patient access report accurately reflects the wait times that veterans experience?

Mr. MISSAL. I haven't looked specifically at those, but what I can tell you is, in our VISN 6 report, where we looked at wait time across a large group of medical centers in Virginia and North Carolina, that the wait times that we calculated were significantly different than the wait times that the facilities had and the VISN as well. It was not just one; it was a number of different facilities had significantly different wait times.

It is somewhat complicated because there are so many different dates that they use to calculate wait times. And what we found is the policies that were in place at the time were not being followed, and that is why our numbers were so significantly different.

Mr. VALADAO. Okay. Is there anything we can do to improve that? I mean, should we mandate some sort of—I mean, I don't like mandates normally, but it seems pretty simple. If someone calls in to make an appointment and it takes them 2 months, where is the confusion?

Mr. MISSAL. I think they need to simplify how they calculate wait times, the number of different measurements they have. I can't emphasize enough how important oversight is to make sure that when they have a policy and procedure that they follow it and they follow it accurately.

ROLLOUT OF ONLINE SCHEDULING

Mr. VALADAO. And then there was a rollout in January 2017 of the online scheduling. Have you had any experience with it? Have

you seen how it is performing? Any early indicators that show any progress at all?

Mr. MISSAL. We have not looked at it. I understand it is a pilot, but we haven't looked at it in any kind of detail.

Mr. VALADAO. All right. Thank you.

I yield back the balance of my time.

Mr. DENT. At this time, I would like to recognize Mr. Ryan for 5 minutes.

Mr. RYAN. Thank you, Mr. Chairman.

Thank you for your service. The deeper I get into the Appropriations Committee, the more valuable I find what you and your team do, so thank you for that.

OPIOIDS TREATMENT MANAGEMENT

I want to just kind of continue on the line of questioning that Representative Jenkins was asking you about, CARA and opiate issues with regard to the VA. We also have reports in Ohio that were allegations of little or no oversight of the refills for opioids.

Services other than medication therapy can reduce the need for opiates to deal with pain, as well. We saw in our trip a couple days ago to the D.C. VA Medical Center, they have a center of excellence, that they have done incredible work in the area of providing integrative medicine, and the clinic found significant evidence of decreased dependence on opioids through some of these techniques.

A lot of these integrative treatments—yoga, meditation, acupuncture, art therapy—they are in very, very high demand. And I was surprised, because I went to the D.C. VA a couple years ago to look at these programs, and the scheduling a few years back versus the scheduling now, of people just being able to walk in and access some of this care, has increased significantly, which I think is—you know, the veterans are voting in the marketplace of what their options are there.

So, when reviewing the recent clinical assessment program reviewed for Cleveland, Ohio's VA clinic, I don't see any mention of routine reviews for the opioid management or reviewing inclusion of integrative medicines. And the report on opiate addiction treatment protocols fails to recognize SAMHSA's inclusion of non-opioid options for treatment of opiate substance use disorders. This includes options such as non-opiate 30-day shots, which you know about, that is minimally invasive for veterans' lives and removes the high provided by opioids.

OVERSIGHT FOR OPIOID PRESCRIPTIONS

So my question is, what are we doing to appropriately provide oversight for these opioid prescriptions within the VA? And are we providing the appropriate amount of resources to the clinics to provide both the reduced opioid use within the realm of integrative medicine?

Mr. MISSAL. Sure. We are doing a number of different things in this area.

First of all, in our inspection program, we change up the various areas that we look at just so we can cover as many as possible. And a couple of years back, we did look at medication and how they were controlling the opioids and other controlled substances. We

are now going to likely be putting that back into the upcoming inspection program that we have. We have had recent discussions on that.

Secondly, we are working on a pain management report, covering how does VA deal with pain management issues, which would be opioids and other medication. That will hopefully be out relatively shortly. It is a national review of what they are doing. VA has an opioid safety initiative going on in an attempt to bring down the amount of opioid use, so we are looking at the impact of that as well.

In addition, as we both are proactive and get referrals on potential misuse of opioids, we are aggressively looking at that as well. And we have a number of open investigations and have brought some other ones as well, aside from making sure people who have done something wrong are brought to justice as a deterrent effect as well, to make sure people know we are watching this as carefully as possible and will bring action as appropriate.

ACTIONS AGAINST PRESCRIPTION DRUG THEFT

Mr. RYAN. So how many people up to this point have we brought action against that was selling pills, stealing pills? How prevalent is that up to this point? I mean, do you have any early data on those?

Mr. MISSAL. It is definitely in the hundreds of cases that we have brought or individuals involved over the years. I believe we have something like 90 active cases right now, which could involve more than one person.

So it is an issue out there, and we are looking at it very closely.

Mr. RYAN. So they are stealing and selling.

Mr. MISSAL. They are stealing and selling, or some of the staff use it in the facilities themselves and then substitute a saline or other substance for the patients.

Mr. RYAN. Thank you.

I yield back.

Mr. DENT. Thank you, Mr. Ryan.

At this time, I would like to recognize the gentleman from Virginia, our Navy SEAL, Mr. Taylor, for 5 minutes.

Mr. TAYLOR. Thank you, Mr. Chairman. I have a bunch of questions.

Thank you for being here. We really appreciate it. This is certainly a personal issue for me. And our district has many, many veterans, fastest growing population of women veterans and OIF/OEF veterans. So I appreciate your time and your work.

RETIRING LEGACY SYSTEMS

Let's talk about legacy systems really quickly. Is there a push in the VA currently to get rid of legacy systems? Because some of these systems are from the 1980s, which is incredible. And I understand it is expensive.

That being said, is there a push to procure new systems that are relevant to today so you are not looking for parts or hardware and stuff like that that is not even made anymore as opposed to building on legacy systems that are still there?

Mr. MISSAL. Right. Secretary Shulkin has made several recent statements about that, and what he has stated is that he is looking very closely at this issue. He wants to study and analyze whether certain systems should be replaced and how exactly to do it.

So, at this point, my understanding is VA has not made any final decisions on what they are going to do with respect to their legacy systems as a whole.

Mr. TAYLOR. Any idea on timing, like, when those decisions will be made?

Mr. MISSAL. I hope it is as quickly as possible, because IT is an issue that we have identified as a problem in a number of our reports.

Mr. TAYLOR. Thank you.

UNIFORM TREATMENT PROTOCOLS FOR SUICIDAL VETERANS

Shifting gears really quickly, on the suicide—and I understand the hotline and everything like that. But what is the proper procedure—not the procedure, but is there a uniform procedure if a veteran, any veteran, walks into a facility and says that they are, in fact, suicidal or having suicidal thoughts? What happens there? And is that uniform across the board?

I know that you mentioned the VA being decentralized, but that seems like it would be something that would have to be uniform policy, you know, if somebody—not the hotline, but they walk in and they are a veteran and they have suicidal thoughts. What happens?

Mr. MISSAL. Right. There are suicide prevention officers at the various facilities, and they are supposed to be notified immediately if a veteran is in danger in any way. And so they should be getting appointments immediately, depending on the urgency of the situation.

Mr. TAYLOR. So if somebody—just a followup. If someone walks in—I walk in and I say I am having suicidal thoughts, what happens? You said, you know, they see about the urgency. They don't take me in?

Mr. MISSAL. They should take you in right away. For something like that, I would expect them to take you in right away and have you see a provider immediately.

Mr. TAYLOR. Just one other followup. I apologize. Is there a uniform policy across the board?

Mr. MISSAL. I believe VA does have policies, but as I said before, they are decentralized. And they do change the application of some of the policies if it makes sense at a particular medical center.

Mr. TAYLOR. I appreciate that.

Just because I am dumb, just to clarify, so it is decentralized, but you are not positive that there is a uniform policy, if somebody walks in and they have suicidal thoughts, what happens.

You know, I am not being argumentative, but I want to know, because this is an issue that has come up in our own VA, as well, too.

Mr. MISSAL. I don't know of the specific policy, but my understanding is that if you are a veteran in urgent need that you will be seen immediately, or you should be seen immediately. And my

understanding is that they would have some policies that cover that. I don't know how specific it is on the suicide perspective.

Mr. TAYLOR. Okay. I will talk to you about that offline, I guess.

Mr. MISSAL. Sure.

ELECTRONIC HEALTH RECORDS

Mr. TAYLOR. I wanted to follow up on the interoperability and legacy systems, as well, too. I understand there is more of that. There has, you know, been a big push for electronic health records.

Are you able to speak to the DOD, 100 percent—so if I come in and I am applying for VA disability, I get out of the military—obviously, 100 percent from VA are from DOD—are you able to see everything that I was treated for, where I was treated for, all those things, so that in fact you are able to, one, expedite that claim but also, two, reduce fraud? Because, obviously, veterans—and you may not hear this from this side that often, but veterans commit fraud sometimes, as well, too. So are you able to see those things with the current technology that is there?

Mr. MISSAL. They have different systems right now. I know that is another issue under discussion, is should they try to have one system. There are workarounds, so there is information that is being transferred from DOD to VA——

Mr. TAYLOR. So there is still discussion about whether they should talk or not or what system they should talk—even though 100 percent of people in the VA are from DOD.

Mr. MISSAL. That is correct.

Mr. TAYLOR. Incredible. Thank you.

Thank you, Mr. Chairman.

Mr. DENT. Thank you, Mr. Taylor.

I guess at this time we will move into our second round of questioning.

VA/IG STAFF EXPANSION

A couple things about your agency's growth, Mr. Missal. As you are aware, Congress provided the IG a generous increase for fiscal year 2017 as part of what your predecessor describes as a multiyear increase to right-size the agency. And I think we took you up to about $160 million in fiscal year 2017, which is about $23 million above what you were in fiscal year 2016, or it is about a 17-percent increase.

And I think you have about 790 full-time equivalents, plus—that is about 100 above what you were the year before. Is that correct?

Mr. MISSAL. That is the plan. Correct.

Mr. DENT. All right. So what progress have you made in expanding staff and adding new locations, especially out west, where you had not very much of a presence?

Mr. MISSAL. Right. Well, we are in the process of trying to hire as aggressively as we can. We are looking for quality people. We want to make sure the people that we hire are of the very highest quality. Every day it seems we have other announcements going out, as we have exemptions to the hiring freeze that is in place now. And we will continue to do that until we get fully staffed up.

With respect to new facilities, we are going to be opening a new office in Salt Lake City. We think that is strategic for our office,

and we believe there is plenty of need in that area. And that is one of the offices we are opening; we are considering some other ones as well.

Mr. DENT. Why Salt Lake City? You said it is strategic.

Mr. MISSAL. Because of the medical centers in the area and the regional office for benefits. We don't have anything that close to that area. We also think it is a good workforce where we can attract good people.

FOR PROFIT SCHOOLS USING THE POST-9/11 GI BILL

Mr. DENT. Okay.

I want to just talk briefly about for-profit schools using the Post-9/11 GI Bill. There have been questions from Congress about the quality of education some for-profit schools are providing veterans who use the Post-9/11 GI Bill. The stories we hear about flight schools, beauty schools, truck-driving schools, et cetera, that are charging high tuition with almost no class time and no job prospects, all paid for by the Post-9/11 GI Bill.

The Student Veterans Association of America recently published research saying that public schools received 34 percent of all Post-9/11 GI Bill funding and produced 64 percent of the degrees, but the for-profit schools use 40 percent of the Post-9/11 GI Bill funds and produced only 19 percent of the degrees.

So is your office investigating high-cost, low-performing for-profit schools that are profiting from the Post-9/11 GI Bill?

Mr. MISSAL. Yes. We have brought a number of criminal cases involving schools that have not lived up to the commitments that they made.

In addition, we have an audit now involving the State-supported agencies that are required to get involved in the authorization for those funds to be used. And we should have that report out in the next few months.

Mr. DENT. Okay. I was going to ask you about that. So the audit is coming in the next few months.

Mr. MISSAL. Yes.

DISABILITY CLAIMS BACKLOGS

Mr. DENT. All right. Very good.

On the issue of disability claims backlogs, we understand that there has been a small uptick in the size of the backlog of VA disability claims. Is your agency continuing to review the processing of claims to judge whether VA needs to implement new systems or workforce increases to keep the size of the backlog low?

Mr. MISSAL. Yes. We have a benefits inspection group that goes and inspects the 56 regional offices and puts out reports as they finish their audits and reviews. So, yes, we are actively looking at the benefits.

GAO HIGH RISK REPORT

Mr. DENT. Thank you.

And then, on the GAO high-risk report, I guess the GAO's February report continues to categorize the VA as a high-risk enterprise in five areas—for example, ambiguous policies and incon-

sistent processes; inadequate oversight and accountability; information technology challenges; inadequate training; and unclear resource needs and allocation priorities—although the GAO report acknowledges the VA has made some improvements, notwithstanding.

Do OIG findings lead you to that same conclusion?

Mr. MISSAL. Yes. We recognize the five areas that GAO found, and many of our reports include one or more of those same inadequacies.

PROGRESS IN REDUCING TIME BETWEEN REPORTS

Mr. DENT. And on transparency and timeliness, you made a commitment to make publicly available all IG reports.

Mr. MISSAL. Correct.

Mr. DENT. We truly appreciate your leadership on that score. In last year's hearing, members were very frustrated that the IG was choosing not to release some reports.

What progress are you making in reducing the amount of time between an investigation and the publication of the report? Members were also frustrated by that issue in last year's hearing as well.

Mr. MISSAL. Right. I think we are making progress. We still have some work products that were in the works when I started that we are still pushing to get out that may be of an older time period. But I think the VCL is a good example of a model of where we want to go. We started that inspection around the beginning of June, and we now have it out in well less than a year. And we are going to try to do better than that.

Mr. DENT. Thank you, Mr. Missal.

My time has expired. I now recognize the ranking member for her questions.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

Mr. Taylor, when we were at the VA medical center on Monday, the very concern that you raised, about the inconsistency of the training, was evident in their description of how it works between the national crisis hotline and their local hotline. And I would like to talk with you more about the concerns, because I share them.

Mr. TAYLOR. Sure.

DISCREPANCIES IN WAIT TIMES DATA

Ms. WASSERMAN SCHULTZ. Mr. Missal, I just want to ask a followup question about the discrepancy in your data on the wait times and what you attribute that to.

I mean, can you clarify what you think is driving the discrepancy between the IG's data on wait times and the VA's data? Because you seem to allude to training and a lack of clarity on policies to be the cause. Do you think there is also a possibility that it is still manipulation?

Mr. MISSAL. We don't rule out any possibility.

With respect to VISN 6, where we found very different numbers than VA, I will give you a concrete example of the difference. So if a veteran has a preferred time, a veteran comes in and says, "I want to be seen on June 1st," the policies in effect at the time said

the scheduler is supposed to put a note there just to, again, make them do an extra step to double-check that that is a real date.

And so we found many instances where there was no note. So if there was no note, then it would default to another date. And that is where we used the other date. VA, in calculating their wait times, didn't do that. So we considered it was in violation of the policy, and so——

Ms. WASSERMAN SCHULTZ. Because they didn't use the veteran's preferred date.

Mr. MISSAL. They shouldn't have used the veteran's preferred date if there was no note there.

CHOICE PROGRAM MEETING REQUIRED SPENDING TARGETS

Ms. WASSERMAN SCHULTZ. Okay. I see. Thank you.

Another troubling aspect about the IG report noted that the VA was meeting—the Choice Program was meeting its required spending targets. And that is kind of odd, because we gave them $15 billion. And part of it was for infrastructure; the other part was for care.

Right now, the Choice Program is on track to hit its expiration date with money left over. So how is it possible that the program didn't have adequate resources?

Mr. MISSAL. I think the issue was with the start-up of it. It started up within 90 days from the legislation. It just took them a while to get the network up where they would be able to be more operational with respect to it. So the first part of it, they just didn't spend the money that was allocated to them.

Ms. WASSERMAN SCHULTZ. So, in the beginning, they seemed to not have adequate resources, or they weren't using the resources that they did have appropriately?

Mr. MISSAL. They weren't using the resources because they hadn't yet built up the network of doctors and providers out there who the money would be going to.

Ms. WASSERMAN SCHULTZ. Okay.

VA OIG RESOURCES NEEDS

And in the spirit of making sure that you continue to have the resources that you need, do you have the resources that you need at the moment to conduct proper oversight?

And, I mean, I know that you mentioned during our meeting you were having a tough time getting reports out. Is the hiring freeze a problem now, and do you anticipate it making the problem worse?

Mr. MISSAL. The hiring freeze clearly impacts us. It is hard to give you a precise estimate of the impact, but we are not able to hire the people that we would like to hire so that we can continue to do our effective oversight. And we are hoping, going forward, with additional funds, that we can put to good use every additional person that we are hiring.

Ms. WASSERMAN SCHULTZ. And you don't qualify for an exemption in the hiring freeze policy?

Mr. MISSAL. Some of our positions do. According to OPM and OMB guidance, I am the head of the agency and allowed to grant the exemption. And under the memorandum, you can do it for na-

tional security or public safety. Much of what we do is in the public safety realm.

We have given our plan for the exemptions to OMB and OPM, and they said to go ahead and follow that plan that we had, and we have been doing that.

Ms. WASSERMAN SCHULTZ. So are you concerned that you will be unable to hire the necessary additional auditors and employees that you need to be able to do the appropriate amount of oversight that is necessary here?

Mr. MISSAL. I am concerned we are not going to have enough of them to do the oversight that we see we should be doing, yes.

Ms. WASSERMAN SCHULTZ. Because of the hiring freeze or not enough resources or both?

Mr. MISSAL. A little bit of both, but the hiring freeze definitely is impacting the number of people we are going to be able to hire.

Ms. WASSERMAN SCHULTZ. In spite of the fact that you have the flexibility in those two areas.

Mr. MISSAL. We can grant exemptions but only in certain situations. So, for our open positions, we estimate it is 50 percent or so of the people in the open positions we are going to be able to hire pursuant to exemptions.

Ms. WASSERMAN SCHULTZ. I would suggest to all my colleagues on the committee that if there is a place that cries out for an exemption if this hiring freeze is going to continue, it would be the OIG at the VA.

Thanks, Mr. Chairman. I yield back.

Mr. DENT. Thank you, Ms. Wasserman Schultz.

At this time, I recognize the gentleman from Arkansas, Mr. Womack.

Mr. WOMACK. Thank you.

I appreciate your testimony, sir. Thank you for your service.

PROACTIVE OIG AUDITING

As you know, one of the things that we are able to do from time to time at this level is take care of our veterans by putting them on some solid ground from a small-business perspective, both from a service-disabled small business or just a veteran-owned small business. I have read and I have seen some data that shows that there is good oversight, or at least oversight, on the programs, but I don't think it has been audited since 2011.

So my question would be specifically, other than just prosecuting people for fraudulent-type activity in these programs, which, as I said, we have read and heard about, is there something, in your experience, that we could be doing that would be more proactive in nature? Instead of us always reacting to a fraudulent activity, what can we do proactively that can give us the proper filters to ensure that we are not having to be reactive on some of these issues?

I hope I am clear in my question.

Mr. MISSAL. Sure.

Mr. WOMACK. What would you recommend, if anything, that we can do that we are not presently doing?

Mr. MISSAL. Well, a few things. One is the oversight, what kind of information you ask for about the program to see if it is fulfilling the goals that you have. Secondly is accountability, when you see

that the programs aren't operating as they should be or there are issues, is to take action as quickly as possible.

When we do an audit of a program, we are looking at a lot of different things. And we want our work—to answer four questions: First, why is it important to do? So, as you point out, those programs are very important. Second, what happened here? And third, why did something happen? Again, that gets to the root cause. If there are issues and for the sake of being able to anticipate, you want to get to the root cause. And finally, who is responsible for accountability?

And so that is what we try to do, and, in your oversight role, I know that you try to accomplish the same objectives as well.

Mr. WOMACK. Yeah, we can't see it all and uncover it all, but my concern is that there are likely some things we can do.

Specifically, are we hampered, are we handcuffed at all by privacy information, by doctor-patient relationships, HIPAA-like restrictions? Is there anything that we could be doing proactively from a legislative point of view that would kind of free up the organization to better understand or control these programs?

Mr. MISSAL. Right. It depends. Obviously, VA, with their healthcare system, has certain privacy issues that are going to impact your oversight role. I think it really depends on the various programs that you have.

But there are lots of opportunities to look at oversight. We try to be as broad as possible in what we look at, and that is why we use inspections, audits, reviews, and investigations, so that we can cover as broad an area as possible.

Mr. WOMACK. Of the known and prosecuted cases, has there been established any kind of a pattern of conduct? Or are they just random? Do they cover the waterfront in terms of fraudulent activity?

Mr. MISSAL. They really cover the waterfront. Obviously, the colloquialism "rent a vet" is very prevalent out there, so we look very carefully at those matters to make sure that the contracts are going to the veterans who qualify for it.

Mr. WOMACK. Is there a geographic area more susceptible to this kind of behavior? I know, for example, in some of the Medicare issues that we see surfacing, there are pockets of places where this seems to be more prevalent than other places.

Mr. MISSAL. Nothing has come to my attention that it is focused on particular geographic areas.

HIRING FREEZE IMPACT

Mr. WOMACK. And then, finally, as it pertains to the hiring freeze, I have a whole other set of questions on that. In your opinion, just in a few words, what limitations does the hiring freeze or any other personnel actions have on the ability to deal with the veteran-owned small-business or disabled-veteran business opportunities?

Mr. MISSAL. We have to pick and choose among the matters that we——

Mr. WOMACK. But is it a priority?

Mr. MISSAL. It is a question of priorities, exactly. And the fewer people we have, the tougher it is going to be to hit our priorities.

Mr. WOMACK. Okay. I know I am out of time. Thank you very much for your testimony.

Mr. DENT. Thank you, Mr. Womack.

At this time, I would like to recognize the gentlelady from California, Ms. Lee, for 5 minutes.

Ms. LEE. Thank you very much.

COLLECTING DATA BASED ON RACE AND ETHNICITY

Good morning, I apologize for being late. I would like to follow up on one of the questions that Mr. Bishop asked with regard to data collection, in terms of disaggregating data based on race and ethnicity.

Earlier this year, we had the chance to visit the VA medical center here in Washington, DC. One of the questions I wanted to get answered but couldn't quite get answered was the utilization of data to track minority-, women-owned businesses, and disabled-veteran-owned businesses. They were able to break down, for example, the percentage of women-owned businesses and other categories, but they did not break it down by race.

So I want to find out—are you capable of doing that? Because it is extremely important to make sure that all companies are given equal opportunities. And when you don't have the data, we don't know if African-American businesses, if Latino businesses, or Asian-Pacific American businesses are participating in the contracting opportunities.

Mr. MISSAL. Right. Well, I know that VA keeps data in a lot of different ways. We have access to VA's databases, but it is really up to them to decide how they want to categorize things. Obviously, if we see something that we think should be covered, we could make a suggestion, but it is really their responsibility to keep their data.

Ms. LEE. But we do have some Federal Government requirements to be sure there is nondiscrimination and equal opportunity for all people in all companies.

Mr. MISSAL. Sure.

Ms. LEE. So I would think, in your position, in terms of investigating and making sure they are compliant, that is not their decision. I mean, we have laws that they should comply with to ensure that African-American, Latino, and Asian-Pacific American businesses are being treated fairly and equally.

Mr. MISSAL. Absolutely. And that is something we could certainly look at, and then we would have to work with them to see how they can get the data.

Ms. LEE. Okay. Could you do that, please?

Mr. MISSAL. We can look into that, absolutely.

Ms. LEE. Okay. Thank you very much.

EFFICIENCY IN PROCESSING CLAIMS

Now let me ask about the Oakland office. First, I thank you very much for following up with some of the requests we have made. Last year, I am told that 53 percent of claims were processed, but we still have about 54 percent in terms of backlog.

What needs to happen to become more efficient in processing these claims? We have had terrible problems at Oakland, and we

are trying to get our hands around it. We have made some progress, but 54 percent of claims unprocessed, is not good.

Mr. MISSAL. I think you see great discrepancies among the regional offices in terms of the backlogs they may have, how quickly they can get through the processes. And, again, I think one of the major issues is leadership and oversight of particular offices there. And so that is something VA should look at, to make sure that they have the proper people doing it, that they are following the policies, and they are moving the claims through as quickly as possible.

Ms. LEE. What would be your oversight role in that, if any, to determine whether or not they are compliant with what we have requested? Do you audit them? Or review?

Mr. MISSAL. We could audit. We could do a less formal process, which would be a review of some kind.

Obviously, when we look at something, we generally make recommendations. We keep a report open until they complete the commitments they made in the recommendation. If we think later on that they have fallen back or they haven't fulfilled what they had said they would and they look like they had at one time, we will definitely go back in and look again.

Ms. LEE. So I would have to make that request of you.

Mr. MISSAL. You have just made it.

Ms. LEE. Thank you very much.

Mr. DENT. Thank you, Ms. Lee.

At this time, I would like to recognize the gentleman from West Virginia for 5 minutes, Mr. Jenkins.

ALLOCATION OF FUNDING INCREASE

Mr. JENKINS. Thank you, Mr. Chairman.

There were discussions relating to your budget, and from the appropriations standpoint, a $159 million annual budget. You had this bump up. You identified 725 FTE equivalents, and you identified 5 areas.

I want to talk about where you are putting the increased funding this last year and into which of these categories from an FTE—you mentioned you do investigations, you do audits, you do contract reviews. I am curious about what staff increases in the subcategory of investigations. And a followup on that topic.

Mr. MISSAL. Sure. We have a number of offices which include investigators, and so we probably have more offices with investigators than any of the other directorates, just because we want to cover as broad an area as possible across the country. So what we have done is we have taken a look at all of the offices, the current staffing, and whether or not it makes sense to add staffing to that.

My personal view is we have a number of smaller offices of investigators. We might have two or three. And, to me, it is just harder to be as productive as you can be. If you are going to work in teams and you have people going off doing different things, it is just harder to do that.

So one of the things we are looking at is building up our smaller offices, because we think that will actually increase the productivity. It is almost as if one plus one equals three, as opposed to two.

Mr. JENKINS. Can you share a breakdown of this, under the fiscal year 2017 budget increase that you got and the ability to hire new people, where in these five subcategories you are actually putting these FTEs?

I hear you about the office size and the number of offices. What I am interested in is what your priorities are. You are putting more staff into contract review? More staff into audits? More staff into investigations? I would like to see where this staff is going and also, moving forward, where you think they need to go.

You know, a little bit of this is audit the auditor. And my curiosity, while we appropriately have asked lots of questions about you holding the VA accountable to what we expect from the VA—I have two VA hospitals in my district. I hear oftentimes from employees, whistleblowers, about their concerns, what they are seeing. And we, of course, turn these folks, appropriately, over to your office.

Mr. MISSAL. Right.

TIMELINE IN RESPONDING TO COMPLAINTS

Mr. JENKINS. Tell me about your timeliness in terms of responding to complaints, the followup with that whistleblower. Because we often hear concerns that we have made the call, we don't get the time and attention, we don't get substantive followup.

How do you evaluate your performance in responding to whistleblower concerns, the employees of these VA hospitals?

Mr. MISSAL. With respect to responding to whistleblowers, we definitely can improve our performance there.

We have a hotline group. The hotline group is in our management and administration group. And they are the ones who take the first look at the approximately 39,000 contacts we get to our hotline.

Every one of those is triaged. So we triage each one of those 39,000. Some we can immediately deal with; others require additional review. Others we will share with some of the other directorates. If somebody says, one of your medical centers in West Virginia, they say there is a problem with a doctor, that will immediately go to our healthcare group. They will look at it to see what should be done. So, if it is an urgent situation, we look at it very, very quickly.

But to your question about where am I looking to increase staff, hotline is one of them. I think we can do more. We can personalize more of the responses that we give to individuals.

And the other area is in our healthcare inspection group. Right now, we have over 200 staff in investigations, over 200 staff in audit. We have about 125 in health care. And given the focus of VA on health care, we need to increase that pretty dramatically.

Mr. JENKINS. Well, I am very interested in serving our veterans and the employees who are taking care of the veterans. I appreciate the interest in the hotline needing to staff up, but I appreciate your sensitivity of the statement, quote, "We can improve."

I will be looking for that improvement so that those who are contacting the Inspector General Office with a concern, that they don't feel like that is going on deaf ears. They don't hear back at times, and they think nobody is listening. I want to make sure you are

listening. And from a staffing standpoint, that is why I want to see, are you investing in the area for the personnel to make sure we are responding to those concerns.

Mr. MISSAL. I agree. Responsiveness and prompt responsiveness is very important to me, because if we don't have it, we are not going to have the confidence that we need to have for veterans and others to think we are doing our oversight work properly.

Mr. JENKINS. Thank you.

I yield back.

Mr. DENT. Thank you, Mr. Jenkins.

At this time, I recognize the gentleman from Georgia, Mr. Bishop, for 5 minutes.

Mr. BISHOP. Thank you very much.

Your audit report found that the VA made about $247 million in improper GI Bill payments and $205 million in missed recoupments annually.

GI BILL BACKLOG AND PROCESSING DELAYS

On 17 March, which was last Friday, the VBA website posted a message stating that veterans and servicemembers can expect processing delays due to an internal audit.

When do you expect that the audit will be completed? How many current GI Bill claims are currently backlogged? And when will the VBA be able to start working through the growing GI Bill backlog?

Mr. MISSAL. I don't have the specific numbers there.

The report that you mentioned identified significant issues with both the payment and the recoupment, and we projected out what the impact could be if they didn't fix it as quickly as possible. So we are following up on that, since they are open recommendations, with respect to that report and that issue to make sure that they fulfill their commitments.

Mr. BISHOP. Do you expect any criminal investigations to come out of that?

Mr. MISSAL. We do have criminal investigations as it relates to the GI Bill funding. And we have had a number of prosecutions, and we have active cases right now.

Mr. BISHOP. Okay. No further questions. Thank you.

Mr. DENT. Thank you, Mr. Bishop.

At this time, I would like to recognize Mr. Taylor.

Mr. TAYLOR. Thank you, Mr. Chairman.

TREATMENT OF INELIGIBLE VETERANS

I have a question, and this is something that maybe you don't get often from this side, I think. But, you know, I walked through my VA and asked a lot of questions, and it was pretty clear there were some folks there that probably were not eligible for the care that they were receiving.

And, again, I mean, from this side, the political pressure, I think, is to treat veterans and be pro-, pro-veterans. But if there are folks that are not supposed to be—you know, they are not rated or they are not supposed to be treated there, then that is, you know, a pretty excessive cost potentially.

My question is—and, like I said, I walked through and I saw this and asked a question, and they definitely verified that. Have there

been any reports that are out there, or have you guys looked into it, as far as potential veterans that are being treated that aren't necessarily supposed to be being treated at the VA?

Mr. MISSAL. I don't believe there has been any report certainly since I have been there. I don't know how far back to go to know whether or not we have done that. Certainly in recent time I don't believe we have looked at it.

We do look at the Health Eligibility Center, which determines eligibility for care. We have done a lot of work in that area, but not to see whether people are getting services who should not be.

Mr. TAYLOR. Obviously, we want everybody to be treated, of course. That is not the point. But, as you can imagine, if there are folks who are not rated to be treated but being treated at a VA, that could be tremendous costs across the whole system.

So is that something that you would be interested in taking up or doing a report on to figure out? You know, "I have the eligibility right here," and veterans know if they are eligible or not, based upon, you know, what is there, of course.

So is that something that your office would be willing to do and a report on to figure out, okay, are there, across the board, in different—whatever the treatment might be, but folks that are—not necessarily that they are abusing it, but if they are not supposed to be treated, then they are not there. And then what is that cost to the VA? Is that something that you would be willing to do a report on?

Mr. MISSAL. We would certainly look at it to see if it is a systemic or other large problem. Any information that you have that would be helpful to us, we would really value getting it from you.

Mr. TAYLOR. All right. I appreciate that. I would love to follow up with you on that to get that report done. Thank you.

Thank you, Mr. Chairman.

Mr. DENT. The gentleman yields back.

At this time, I recognize the gentleman from Ohio for 5 minutes.

Mr. RYAN. Thank you, Mr. Chairman.

I want to review the numbers from your testimony for a minute here.

As I understand it, your organization has a return of investment of $30 for every dollar of Federal funding, which is pretty impressive. Despite that, the skinny budget from the President is proposing to flat-line the VA discretionary programs, which you are included in. And so my concern is that this one-size-fits-all plan ignores your planned staffing increases designed to champion and protect our veterans health care and benefits, as you already do, by reducing costs.

In addition to failing to meet this promise, if I continue to follow the math correctly, we talk about a potential repeal of the healthcare bill would cause 24 million Americans to lose their health care, which would increase veterans' participation into the VA program and generate an even larger need for you and your oversight and the precious funds that you have.

UNMET FUNDING NEEDS

So the question is, is that a reasonable estimation to say that $30 million would be the number if we follow the President's in-

tended funding? And if the VA sees an increase from the repeal of the current healthcare system options that many veterans take advantage of, would your staffing and budget needs also increase?

Mr. MISSAL. It likely would. I don't know and I haven't seen the numbers of what the impact would be if there is a repeal, but any type of increase in the use of VA, whether it is the healthcare system, whether it is benefits, would then cause us to have additional responsibility.

So there are other variables that could come into play that could impact the funding that we have and our ability to do effective oversight.

Mr. RYAN. So you are flat-lined. And for every dollar, you save 30.

Mr. MISSAL. Correct.

Mr. RYAN. And if 24 million people lose their health care, I don't know what the exact number would be, but we would assume that hundreds of thousands, at least, would be veterans——

Mr. MISSAL. Right.

Mr. RYAN [continuing]. Who would then go into the VA system because they wouldn't have anywhere else to go. So that, to me, seems like it would have a huge impact on the VA and your ability to try to continue to save us money.

Mr. MISSAL. Right.

And if I could just add one thing, on the 30 to 1, that is the amount of dollars that we save or the impact that we have. We are one of the few IGs that also has healthcare responsibilities. And so on those, it is not a dollar return. What you are talking about is helping to save lives, helping to have better medical care. And so that should be on top of the 30 to 1. And to use a commercial, we consider that priceless and very important to what we do.

Mr. RYAN. Excellent. Thank you.

Mr. DENT. At this time, I would like to recognize the gentleman from Arkansas, Mr. Womack, for 5 minutes if he has questions.

HIRING FREEZE EXEMPTIONS

Mr. WOMACK. I won't need all that time. I just want to go back to hiring freezes for just a minute.

You detailed in your written statement that, based on guidance from OMB and OPM, you have the authority to determine what positions in the OIG are subject to the Presidential memorandum on the freeze of hiring. You also stated you exempted some on the basis they were involved in national security or public safety responsibilities.

And I apologize if this has already been covered. I got here late today.

With that in mind, can you give us an example of a position within the OIG that involves national security or public safety responsibilities that would be exempted?

Mr. MISSAL. Sure.

On public safety, we have a number of positions that we feel should be exempted under public safety and we have exempted under public safety, such as criminal investigators, such as auditors looking at significant programs which could have a significant impact on taxpayer dollars, and our healthcare inspectors and pro-

viders who are looking at the medical centers, medical facilities to help make the healthcare providers at VA work more effectively.

Mr. WOMACK. How tight are those conditions? In other words, you could probably make an argument from agency to agency that a lot of these types of positions are geared to do exactly what you just said. So is it as simple as giving it a general umbrella that because they work in this particular area that we can automatically exempt, or are they pretty tightly reserved there?

Mr. MISSAL. We are looking at every position on a case-by-case basis. We are taking the memorandum very seriously. We were asked to consult with OMB and OPM, and we did so. And they agreed with our plan in terms of the types of positions we were going to grant exemptions to.

Mr. WOMACK. In those positions, what would be the churn rate, typical churn rate of in and out? Are these revolving-door positions, or are these people who have been there a long time? How would you characterize the general character of this particular lot of employees?

Mr. MISSAL. Our turnover rate is relatively low. We have a very dedicated and committed staff that is really focused on our important mission. And so when people come to us, they stay for quite a few years. Our hope is that when they come to us, that they are going to be there for a long time.

Mr. WOMACK. And then, finally, for those that would not fit under that category that you discussed a moment ago, what would be an example of those kinds of positions?

And then, if you can, is there a general breakdown as to X percent of my team should be exempted and X percent could be not considered for an exemption status?

Mr. MISSAL. Right. A lot of the administrative positions that we have, I think, are harder to make the public safety or national security argument for. You are right; I mean, you can make arguments for virtually everything, because what we do is help improve the VA's programs and operations, help make them as effective as possible, and to ensure taxpayer money is spent properly. Everybody in our office, to some degree, is focused in on those two missions.

But it is hard to say at this time exactly how many we will have. We estimate it is around 50 percent of the open positions. But we are looking at them position by position.

Mr. WOMACK. That is all I have, Mr. Chairman. Thank you.

Thank you again for your testimony.

Mr. MISSAL. Thank you.

Mr. DENT. Thank you, Mr. Womack.

At this time, I recognize the gentlelady from California, Ms. Lee, for 5 minutes.

DATA REPORTING BY RACE AND ETHNICITY

Ms. LEE. Great. Thank you again, Mr. Chairman, for giving me a chance to ask my second round of questions.

I want to go back to the questions I asked you earlier with regard to the disaggregation of data as it relates to ethnic and racial inclusion in the business aspects and contracting opportunities.

The "National Veteran Health Equity Report" "released in 2016" suggested that "tools for measuring parameters of interest by race/ethnicity should be incorporated into the next generation of the VA electronic health record user interface." As this data base develops, interventions to reduce health and healthcare disparities should be implemented and evaluated," especially identifying the causes of racial and ethnic disparities in the VA.

Now, in this report, I didn't find the answer to some of the questions I had—specifically relating to emergency rooms, and wait times to see a doctor. I wanted to see, as it relates to the average wait time in an ER, this data disaggregated by race and ethnicity overall. Are all things equal? Are all wait times not very good, or are all of them are great? Or for veterans of color, is there a lower wait time? A higher wait time?

I would like to get that information clarified, because I have had personal experience with this. I have visited in several emergency rooms in different parts of the country, and looking at the population of veterans, there seems to be some disparities there. I would like clarity on that.

Mr. MISSAL. Okay. That is something that we can look at and we can see what data the VA has and what they should have as well. At this point, we have not looked at those particular questions.

Ms. LEE. Okay. Well I would appreciate you looking into this. Because this is very serious, and I have seen many cases in California that give me some concern. We need to address it.

NURSING PAY SCALES

Secondly, in a September 2016 report, you found that nursing care was the top critical need occupation for fiscal year 2016. To ensure adequate levels of staff to provide timely access to care, of course, continuity of care is extremely important.

Going back to the Oakland regional office—there is a real discrepancy in the pay scale for registered nurses in the Oakland-Fremont area. There are regional pay disparities, which is causing a huge problem in retention at the VA outpatient clinic. I think Fremont is 30 minutes away from Oakland—and we can't figure out how to address these pay discrepancies, which cause retention problems in the medical facilities. I wanted to see if you found any recommendation on how to address that.

Secondly, there is not a nursing shortage—but there are nurses, qualified nurses, who are unemployed and can't seem to find a job. So I am wondering, if there are licensing issues with the VA? Why is it that this gap still exists?

Mr. MISSAL. Right.

So we were asked legislatively to look at the largest number of open positions. You have identified nursing as one; there were five others that we looked at. And I think this was our third year that we did it. We are going to be doing it over 5 years.

One of our recommendations was that VA needs to have a staffing plan to do precisely the issues that you raise—to make sure that they have proper staffing, it is allocated the proper way, et cetera. And so we are still following up with them to ensure that they do have that proper staffing plan, and we will continue to do so.

Ms. LEE. I know they don't have a plan. I don't know about other regions, but I know they just don't have it in my district. And I know that pay disparities and discrepancies are a problem in California. I also know that they are not hiring nurses who are looking for jobs. So that is another layer of trying to figure out what is going on. Also how are they following up or are they just not following up?

Mr. MISSAL. I believe there was legislation introduced in the last Congress about increasing pay for certain positions at VA. And, you know, that could be one way to address the situation.

Ms. LEE. Thank you very much. I appreciate your being very candid with us in your answers.

Mr. MISSAL. Thank you.

Mr. DENT. Before we conclude, I would like to recognize Mr. Bishop.

VA ANIMAL RESEARCH

Mr. BISHOP. Thank you.

Just one matter. You recently received a letter, which was copied to members of our subcommittee, from the White Coat Waste Project requesting that you conduct an investigation regarding animal experimentation at the McGuire VA Medical Center.

Do you intend to undertake that investigation? And do you have any idea how long that will take and whether or not—well, could you just furnish us with whatever your findings are?

Mr. MISSAL. Sure. I got the letter about 5 o'clock last night.

Mr. BISHOP. Right.

Mr. MISSAL. I read the letter. I responded to the gentleman who sent it, saying we will review it. And we are in the process of reviewing it and will determine whether or not it is something that makes sense for us to do.

Mr. BISHOP. Thank you.

Mr. DENT. Thank you.

I have no further questions, although I will submit—I do have questions, actually, but I am going to submit them for the record for you to respond to, Mr. Missal.

And, again, I want to thank you and thank the ranking member and all the members who attended today's hearing.

So, again, appreciate your testimony and your responsiveness.

I should mention one thing before I adjourn. The subcommittee's next hearing is Wednesday, March 29, at 10 a.m. in this room. We are going to hear from outside public witnesses.

So, having said that, this meeting is now adjourned.

[Questions for the record submitted by Chairman Dent for the Honorable Michael J. Missal follows:]

Question: Please address in detail each specific VA high risk area GAO identified in its February report – the IG assessment of the level of risk, improvements VA has made since the previous GAO report, and resources (staffing, technology, etc.) required to overcome the risk.

Answer: Although the Office of Inspector General (OIG) shares an analogous mission with the Government Accountability Office (GAO), we do not specifically track VA's progress in implementing GAO's recommendations. While the OIG's work is determined by what we believe is the most effective oversight of VA, many of our reports address the same five areas of concern identified by GAO in placing VA on its High Risk list. The OIG testified at two recent hearings, and our written testimony highlights OIG reports that echo GAO concerns and may be of interest to you.[1]

Question: Please provide the data supporting the comparison in the testimony between the size of the VA OIG versus IGs in other Federal agencies in terms of percentage of agency full-time equivalent staffing and size of agency budget.

Answer: The following charts demonstrate how the VA OIG compares to other OIGs as both a percentage of the agency's full-time employee equivalents (FTE) and budget using fiscal year (FY) 2016 enacted levels and the President's FY 2017 budget request. We relied on the President's FY 2017 budget request given that most of the Federal government is operating on a Continuing Resolution at FY 2016 funding levels.

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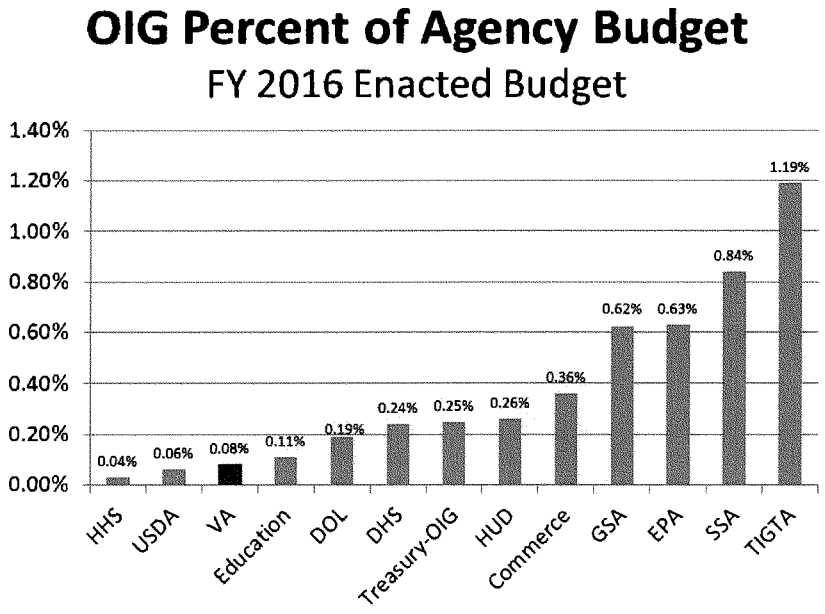
[1] See *Statement of Michael J. Missal, Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States Senate, Hearing on "The Government Accountability Office's High Risk List And The Veterans Health Administration"* (March 15, 2017) and *Statement of Michael J. Missal, Inspector General, Department of Veterans Affairs, Before the Committee on Homeland Security and Governmental Affairs, United States Senate, Hearing On High Risk: Government Operations Susceptible To Waste, Fraud, And Mismanagement"* (February 15, 2017).


OIG Percent of Agency Budget
FY 2016 Enacted Budget
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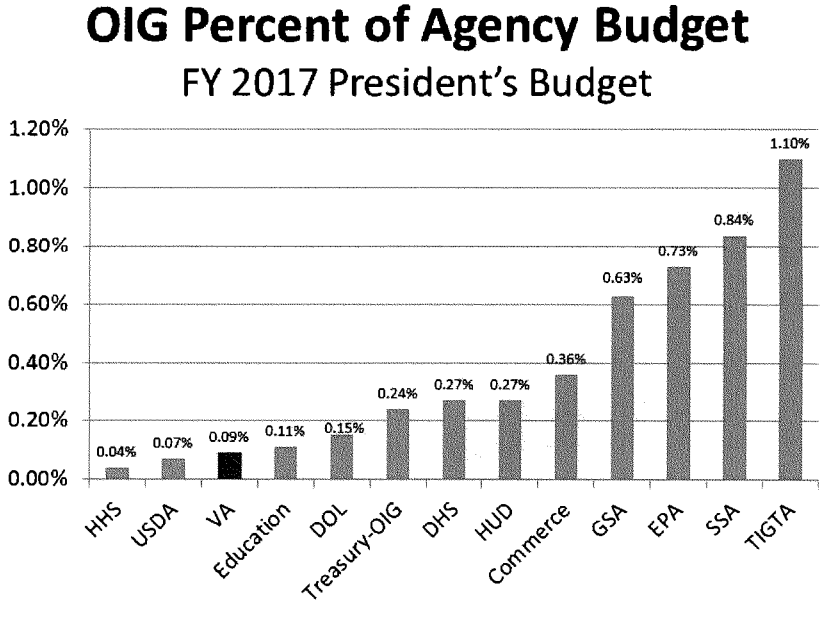
1.20%
1.00%
0.80%
0.60%
0.40%
0.20%
0.00%
0.04%
0.06%
0.08%
0.11%
0.19%
0.24%
0.25%
0.26%
0.36%
0.62%
0.63%
0.84%
1.19%
HHS
USDA
VA
Education
DOL
DHS
Treasury-OIG
HUD
Commerce
GSA
EPA
SSA
TIGTA


OIG Percent of Agency Budget
FY 2017 President's Budget
1.20%
1.00%
0.80%
0.60%
0.40%
0.20%
0.00%
0.04%
0.07%
0.09%
0.11%
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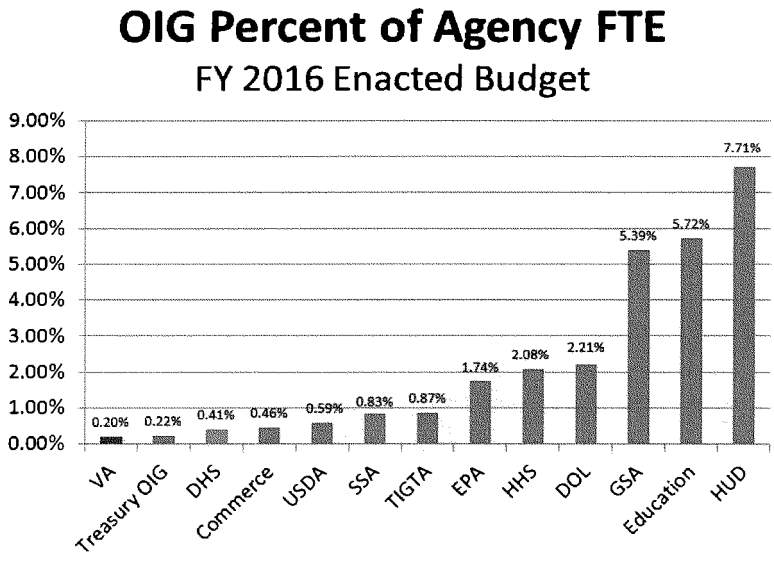
0.63%
0.73%
0.84%
1.10%
HHS
USDA
VA
Education
DOL
Treasury-OIG
DHS
HUD
Commerce
GSA
EPA
SSA
TIGTA


OIG Percent of Agency FTE
FY 2016 Enacted Budget
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
0.20%
0.22%
0.41%
0.46%
0.59%
0.83%
0.87%
1.74%
2.08%
2.21%
5.39%
5.72%
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TIGTA
EPA
HHS
DOL
GSA
Education
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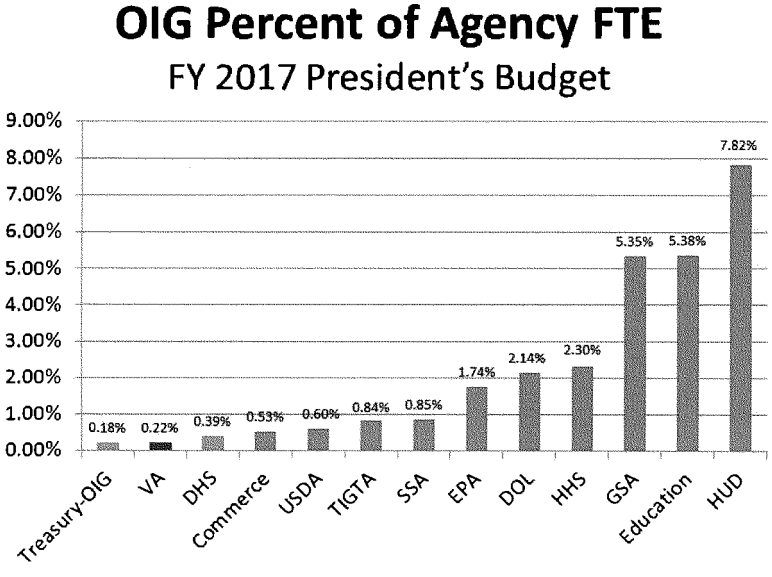
OIG Percent of Agency FTE
FY 2017 President's Budget
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
0.18%
0.22%
0.39%
0.53%
0.60%
0.84%
0.85%
1.74%
2.14%
2.30%
5.35%
5.38%
7.82%
Treasury OIG
VA
DHS
Commerce
USDA
TIGTA
SSA
EPA
DOL
HHS
GSA
Education
HUD

Question: Provide a chart of total VA IG FTE by month in FY16, FY17, and FY18 (estimated) versus the long-term rightsizing plan put forward by the OIG.

Answer: The table below shows actual FTE for FY 2016 through the first half of FY 2017 and planned growth for the next 18 months.

	FY 2016 Actual	FY 2017 Actual	FY 2017 Estimate	FY 2018 Estimate
October	662	685	--	765
November	666	692	--	770
December	667	690	--	775
January	668	691	--	780
February	669	696	--	785
March	671	705	--	790
April	672	--	715	795
May	675	--	724	800
June	676	--	733	805
July	678	--	742	810
August	679	--	751	815
September	680	--	760	820
"Right Size" Plan	--	--	**790**	**975**

Question: Identify the estimated total funding carryover from FY2017 to FY2018.

Answer: The current estimate for FY 2017 end-of-year carryover is somewhere between a best-case/worst-case scenario of $10-24 million, or 6.5-15 percent of our FY 2017 appropriation. Since a large majority of our funding is for salaries, the hiring freeze did have some impact on our ability to recruit for certain positions that were exempted. Now that it has been lifted we are working aggressively to make up for lost time and recruit to fill all of our openings. While we are optimistic that we will be successful in hiring spending down our funds to carry over no more than the 10 percent authorized by law, we also recognize that Federal hiring is at times not a fast process. We do not want to overlook the possibility of additional restrictions that may be put in

place by the Administration during FY 2017 that could impact our ability to fill these vacancies.

Question: In the recent audit of VISN 6 scheduling, what share of the cases OIG identified as exceeding the 30-day service deadline was declared as not having met the scheduling deadline because nothing was entered into the "notes" section of the file, even though the appointment did take place within 30 days or the requested date?

Answer: In our assessment of new patient wait times at Veterans Integrated Service Network (VISN) 6 VA medical facilities, we identified 164 out of 618 (26.5 percent) statistically sampled new patient appointments that exceeded 30 days. Of those, we determined 31 of the 164 (19 percent) sampled appointments exceeded 30 days because there was no other evidence, such as comments in the scheduling system, to support the entered preferred date was based on the patients' request. In those instances (31 of 164), we measured the wait time from the date the appointment was created by the scheduler.

Question: You indicate that you have created a Rapid Response team for your healthcare inspections unit. What are the sort of incidents that you expect this team to handle that the OIG didn't have the capacity to do before?

Answer: The purpose of the Rapid Response team is to investigate rapidly and report on significant healthcare related issues. Previously, there was not a team of seasoned inspectors whose sole job was to focus on complaints that required an immediate response. Further, the leadership of OIG is committed to prioritizing resources to this team so that this effort is successful. The goal is to: (1) have a team onsite within days of notification of an event, (2) quickly ascertain the critical issues that must be addressed by the Veterans Health Administration (VHA), and (3) timely report to the VA, Congress, and public on the actions taken to ensure veterans receive the highest quality healthcare. The Interim Summary Report, published April 12, 2017, that addresses issues at the Washington DC VA Medical Center (VAMC) is a recent example of the value this team brings to the OIG and the support from within the OIG to make this team's findings impactful.[2]

Question: Your testimony indicates that you are introducing a system that will replace VHA 'Clinical Assessment Program' (CAP) reviews.

How will the new 'Comprehensive Healthcare Inspection Program' (CHIP) reviews differ from the current CAP reviews?

Answer: OIG Response: The Comprehensive Healthcare Inspection Program (CHIP) review will have an increased focus on the actions taken by facility leadership to address the challenges the hospital must address to provide quality medical care. The CHIP review will also place a greater emphasis on hospital quality of care data,

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[2] *Interim Summary Report, Patient Safety Concerns at the Washington, DC, VA Medical Center, Washington, DC* (April 12, 2017).

employee and patient satisfaction scores (comments), and actions taken by leadership to address issues raised by VA and non-VA hospital reviewers.

Question: What information do you expect to receive from the new reviews that has been lacking in the CAP reviews? Do you have a similar periodic review system for VA disability claims processing?

Answer: The OIG expects to have a better understanding of the underlying cause of conditions that exist in the hospital that present a risk to veterans' receiving appropriate quality healthcare, not just that the condition exists. Additional data on patient satisfaction and leadership performance will enhance the facility review.

The OIG's Benefits Inspection Program is part of the OIG's efforts to ensure veterans receive timely and accurate benefits and services. These independent inspections, which are completed on each of the 57 VAROs on a 3-year cycle, provide recurring oversight of VAROs, focusing on disability compensation claims processing and performance of Veterans Service Center operations. The objectives of the Benefits Inspection Program are to evaluate how well VAROs are accomplishing their mission of providing veterans with convenient access to high quality benefits services and report systemic trends in VARO operations. Benefits Inspections also determine whether management controls ensure compliance with VA regulations and policies, assist management in achieving program goals, and minimize the risk of fraud, waste, and other abuses. We expect to begin publishing our next round of reports in summer 2017.

Question: How will your new Data Analytics Council use VA's "big data" across all of VA's programs to identify previously unrecognized high risk areas?

Answer: OIG Response: As background, OIG's Data Analytics Council (DAC) is the principal entity commissioned by the IG to serve as a source for complex data analytics initiatives across the VA OIG. The DAC will establish and maintain the policies, processes, and standards governing the management of OIG collaborative data initiatives, actively solicit input from internal stakeholders and external partners to help better detect high risk programs, and identify responsibilities and establish the rules upon which OIG will choose, prioritize, plan, execute and report on data analytics projects. The data for these programs will be analyzed and profiled, with anomalies being further investigated to identify fraud, waste or abuse, or other systemic internal control or patient care issues.

[Questions for the record submitted by Congressman Rooney for the Honorable Michael J. Missal follows:]

Question: My constituent services representatives in charge of veterans' casework in my district are still receiving complaints about long wait times for VA appointments, referrals, and payments through the Choice program. The slow payment and reimbursement process has been especially challenging for veterans in my district, which is extremely rural. Rural areas tend to have smaller hospitals and community clinics, and types of health care facilities are often faced with lower profit margins. Many providers that are technically participating in the Choice program are refusing to accept Choice patients because they know they will have to wait a long time to get paid by the VA. Waiting for that payment puts these providers in a tough financial situation. Some providers that do accept Choice patients will only do so if the veteran agrees to pay for services up front. This leaves veterans in the same bind they were in before Choice – facing excessive wait times at VA facilities with no option to obtain immediate care elsewhere without paying a fortune out of pocket.

We've been trying to improve Choice since it was authorized. Which recommendations have your office made to improve the Choice program? Of these recommendations, which ones have been implemented? Of those implemented, which ones are working, and how effectively? Has your office made any recommendations related to Choice that have not yet been implemented that you think could drastically improve the program?

Answer: The table below lists the six recommendations made in our report.[1] The VA OIG follows up on open recommendations on a quarterly basis. Our recommendation made in January 2017 will require a response from VHA in late April 2017 on their progress in implementing our recommendations. We believe the recommendations will improve access for veterans if they are successfully and timely implemented. The then Under Secretary for Health concurred with our findings and recommendations and provided acceptable corrective actions. Additionally, he stated that Recommendations 4, 5, and 6 were completed. Once the OIG receives evidence of implementation, we will examine it and determine if VHA's actions are sufficient to close the recommendations.

[1] *Veterans Health Administration, Review of the Implementation of the Veterans Choice Program* (January 30, 2017).

Recommendation	Status
1. We recommended the Under Secretary for Health streamline processes and procedures for accessing care under the Veterans Choice Program.	Open
2. We recommended the Under Secretary for Health develop accurate forecasts of demand for care purchased in the community.	Open
3. We recommended the Under Secretary for Health simplify requirements for network providers to bill for services under the Veterans Choice Program.	Open
4. We recommended the Under Secretary for Health ensure eligible veterans are not financially liable for the full cost of treatment authorized under the Veterans Choice Program.	Open
5. We recommended the Under Secretary of Health ensure community providers are paid in a timely manner under the Veterans Choice Program.	Open
6. We recommended the Under Secretary for Health review the Veterans Choice Program to determine if growth of provider networks is being limited by allowing reimbursement below Medicare rates.	Open

Question: The contractors chosen by the VA receive a lot of blame from the VA. Do you think that there are components of Choice that could be more effectively carried out by the VA, rather than a contractor? Is there sufficient oversight over the performance of VA contractors? Is there a method for the VA to hold poor-performing contract employees accountable? Are poor-performing contract employees easier or harder to hold accountable?

Answer: Choice was preceded by the Patient-Centered Community Care (PC3) Program—a VHA nationwide program that utilizes service contracts to provide care for eligible veterans when the local VA medical facilities lack available specialists, have long wait times, or are geographically inaccessible. In September 2013, VA awarded the initial PC3 contracts to third-party administrators (TPAs)—Health Net Federal Services, LLC (Health Net) and TriWest Healthcare Alliance Corporation (TriWest) as a supplement to the Non-VA Care (NVC) Program. PC3 began health care delivery in January 2014.

In October 2014, VA amended the PC3 contracts, adding $300 million to their value, with Health Net and TriWest, to include the administration of Choice. VA's use of the same contracts to administer the Choice program is significant because the OIG has highlighted a number of weaknesses in VA's oversight of the PC3 contracts in a series of reports we published in FYs 2015 and 2016. The issues we identified include authorizing, scheduling, inadequate provider networks, ensuring contractors provide medical information to VA in support of the services provided, ensuring VA inputs the medical information from contractors into the veteran's VA medical record, and timely and accurate payment for care purchased outside the VA health care system.[2] These reports criticized many of the weak metrics used to measure contractor performance, VA's lack of independent data sources to validate contractor performance claims, and VA's poor oversight in monitoring contractor performance or applying disincentive penalties. Since publishing our PC3 reports, we have continued to see oversight issues in regards to the PC3 and Choice contracts. For example, our January 2017 report on the VA's implementation of Choice echoed many of the problems found with the PC3 contracts.[3] The table that follows lists OIG recommendations in the aforementioned PC3 and Choice reports.

Currently, we are undertaking a review of Choice payment timeliness and accuracy, which we are aiming to complete by the third quarter of FY 2017. Our review is focused on VA's oversight of contractor payment timeliness to its network providers. The current PC3/Choice contracts do not have performance measures to ensure contractors pay their providers in a timely manner. Because VA is a secondary payer in the Choice program, veterans are at risk for being billed by providers when payments are not processed in a timely manner. This issue was highlighted in our January 2017 Choice report as well.

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[2] *Review of the Award of the Patient-Centered Community Care (PC3) Contracts* (September 22, 2016)
Review of Patient-Centered Community Care (PC3) Health Record Coordination (September 30, 2015)
Review of Patient-Centered Community Care (PC3) Provider Network Adequacy (September 29, 2015)
Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues (July 15, 2015)
Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings (April 28, 2015)

[3] *Review of the Implementation of the Veterans Choice Program* (January 30, 2017)

Report	Recommendation	Status
Review of the Implementation of the Veterans Choice Program (January 30, 2017)	1. We recommended the Under Secretary for Health streamline processes and procedures for accessing care under the Veterans Choice Program.	Open
	2. We recommended the Under Secretary for Health develop accurate forecasts of demand for care purchased in the community.	Open
	3. We recommended the Under Secretary for Health simplify requirements for network providers to bill for services under the Veterans Choice Program.	Open
	4. We recommended the Under Secretary for Health ensure eligible veterans are not financially liable for the full cost of treatment authorized under the Veterans Choice Program.	Open
	5. We recommended the Under Secretary of Health ensure community providers are paid in a timely manner under the Veterans Choice Program.	Open
	6. We recommended the Under Secretary for Health review the Veterans Choice Program to determine if growth of provider networks is being limited by allowing reimbursement below Medicare rates.	Open
Review of the Award of the Patient-Centered Community Care (PC3) Contracts (September 22, 2016)	1. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) ensure sufficient oversight on all high-dollar value and complex acquisitions to prevent violations of acquisition regulations and VA policies.	Open

	2. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) ensure critical planning actions—requirements development, market research, and independent government cost estimates are performed and provided to contracting officers, prior to developing requests for proposals.	Open
	3. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) obtain pricing analysis and technical assistance, to ensure quality products and services are procured at fair and reasonable contract prices.	Open
	4. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) enforce compliance with the VA policy to document all required acquisition decisions in the Electronic Contract Management System.	Open
Review of Patient-Centered Community Care (PC3) Health Record Coordination (September 30, 2015)	1. We recommended the Under Secretary for Health implement a mechanism to ensure payments are not made to Patient-Centered Community Care contractors until all required clinical documentation is received.	Closed
	2. We recommended the Under Secretary for Health enforce Patient-Centered Community Care contract performance requirements to ensure that contractors return complete clinical documentation timely.	Closed

	3. We recommended the Under Secretary for Health implement a mechanism to verify contractors' performance without relying on contractors' self-reported data.	Closed
	4. We recommended the Under Secretary for Health complete a review of TriWest's performance and apply penalties if it is determined there is a lack of performance related to the timely return of clinical documentation.	Closed
	5. We recommended the Under Secretary for Health review the contract disincentives applied to HealthNet and determine if additional funds need to be recouped from the contractor and pursue collection if disincentives were under applied.	Closed
	6. We recommended the Under Secretary for Health ensure that Patient-Centered Community Care contractors annotate on all diagnostic imaging reports and non-imaging-related critical findings submitted to VA the name of the VA person contacted, and the date and time of the contact.	Closed
	7. We recommended the Under Secretary for Health implement procedures to verify whether Patient-Centered Community Care contractors and their network providers correctly and timely report critical findings to VA and impose financial penalties or other remedies when contractors fall below the contract performance threshold.	Closed
Review of Patient-Centered Community Care (PC3) Provider Network Adequacy (September 29, 2015)	1. We recommended the Under Secretary for Health ensure the establishment of an adequate governance structure to oversee and improve Patient-Centered Community Care management and operations.	Closed

	2. We recommended the Under Secretary for Health ensure adequate implementation and performance monitoring plans are developed for future high-dollar, complex health care initiatives.	Closed
	3. We recommended the Under Secretary for Health assess where Patient-Centered Community Care provider networks are inadequate and develop action plans to improve provider networks that are unable to provide health care services at the specific geographic locations identified.	Closed
	4. We recommended the Under Secretary for Health ensure the Patient-Centered Community Care Quality Assurance Surveillance Plan is revised to address the monitoring and measurement of network adequacy.	Closed
	5. We recommended the Under Secretary for Health require the input of National Provider Identifier information for rendering providers in the Fee Basis Claims System to ensure adequate data are available for program evaluation and planning.	Closed
Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues (July 15, 2015)	1. We recommended the Interim Under Secretary for Health establish timeliness criteria for submitting authorizations to the Patient-Centered Community Care contractors.	Closed
	2. We recommended the Interim Under Secretary for Health monitor timeliness of submitting authorizations to Patient-Centered Community Care contractors and take actions to improve timeliness when standards are not met.	Closed
	3. We recommended the Interim Under Secretary for Health evaluate the	Closed

	Patient-Centered Community Care contractor networks to ensure they are sufficient to meet contract performance requirements.	
	4. We recommended the Interim Under Secretary for Health revise contract terms to eliminate the option of scheduling appointments before communicating with the veteran.	Closed
	5. We recommended the Interim Under Secretary for Health implement a control to ensure Patient-Centered Community Care contractors return authorizations if they cannot schedule an appointment within 5 business days of receipt of the authorization.	Closed
	6. We recommended the Interim Under Secretary for Health implement a control to ensure Patient-Centered Community Care contractors return authorizations when they cannot arrange for an appointment to take place within 30 days of the appointment creation date.	Closed
	7. We recommended the Interim Under Secretary for Health implement a control to ensure Patient-Centered Community Care contractors comply with requirements to notify Veterans Health Administration within 14 days of a missed appointment.	Closed
	8. We recommended the Interim Under Secretary for Health implement a control to ensure Patient-Centered Community Care contractors comply with requirements to return medical documentation within 14 days of the appointment's occurrence.	Closed
	9. We recommended the Interim Under Secretary for Health implement a	Closed

	mechanism to monitor all authorizations submitted to the Patient-Centered Community Care contractors.	
	10. We recommended the Interim Under Secretary for Health revise the Patient-Centered Community Care dashboard to report completed authorizations and the percentage of total authorizations by the specific contractors performing these services.	Closed
Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings (April 28, 2015)	1. We recommended the Interim Under Secretary for Health assign an accountable senior executive to prepare and document revised Patient-Centered Community Care price analyses and determine if VA will realize any cost savings during the future option years of the contracts.	Closed
	2. We recommended the Interim Under Secretary for Health develop an action plan to address low PC3 contract utilization rates.	Closed
	3. We recommended the Executive Director, Office of Acquisition, Logistics, and Construction ensure all required contract documents are maintained in the official Patient-Centered Community Care contract files in accordance with Federal Acquisition Regulation and hold the contracting officer accountable for ensuring complete and accurate information is maintained in the Electronic Contract Management System.	Closed

Question: My constituent services representatives have also told me about veterans who retire or move to my district and subsequently have trouble receiving their usual level of care. These veterans have active treatment plans with other VA hospitals across the country before they move to my district. When they visit their new VA facility

in my district they are told to start a new treatment plan or return to the state where they originally received care.

One of the veterans in my district travels back to his home state in the Midwest just to receive care from the VA. How common is this issue and is it unique to states like Florida that attract a large number of retirees? What is preventing Florida VA medical facilities from better serving these new residents? Can one VA hospital transfer a veteran's treatment plan to another VA hospital? What obstacles are impacting one hospital's ability to transfer a veteran's treatment plan to another hospital?

Answer: Questions related to this specific matter should be directed to VA and specifically the Veterans Health Administration (VHA). Within the VA electronic health record (EHR), it is possible to see the medical records of a veteran who receives his or her care at another VA, or who has been seen in the Department of Defense. The treatment plan is often set forth in a consult from a specialist to the primary care provider. If the consultant was in VA, the data should be present in the clinical notes. If the consultant does not work for VA, then the consult report may be more difficult to find in the EHR or not available if it has not been uploaded into the VA EHR.

Question: You've mentioned improving IT services and the use of EHRs throughout the VA. What other recommendations has your office made to improve continuity of care for our veterans? Are there any open recommendations aimed at addressing this specific problem?

Answer: We have not made continuity of care recommendations specific to these areas. Patients who are cared for by VA, and who receive a portion of their care from non-VA sources, depend upon the efficient functioning of "data exchanges" to permit the VA EHR to communicate with the non-VA EHR. The OIG has not addressed this issue, but believes the support of these "data exchanges" is critical to the success of VA's use of non-VA providers.

Question: Our country is facing the worst drug crisis in its history. In your testimony, you note that you've conducted 49 investigations resulting in charges related to illicit drug activity to 55 individuals. A recently released GAO report has detailed a lack of oversight and accountability at VA hospitals, specifically related to substance inspection programs. The report indicates that one VA facility missed 43 percent of its monthly inspections in critical patient care areas and the pharmacy over the course of a year. At two of three facilities reviewed, inspectors did not properly verify that controlled substances had been transferred from VA pharmacies to patient care areas. Additional news reports suggest that some drugs at VA facilities have gone missing or simply "disappeared."

Last week the House passed a bill to give the VA secretary greater flexibility to fire bad or poorly-performing employees. One of the most disturbing instances reported by the GAO involved a VA employee who was injecting himself with fentanyl meant for surgical patients, refilling the syringes with saline and putting them back for later use. His actions

and his contaminated syringes caused several patients to contract Hepatitis C. When your office comes across cases like this – where VA employees' actions risk the health and safety of the veterans in their care – what are some recommendations you've offered to help the VA and its contractors make sure employees like this don't make it through the hiring process? Is the VA doing a good job of implementing background checks on people they hire directly and through contractors? Have VA facilities become more proactive in firing bad employees before your office finds out about them?

Answer: In March 2015, we reported VA needed to improve the management of its Drug-Free Workplace Program to ensure the program was effective in maintaining a workplace that is free from illegal drug use.[4] We identified program weaknesses and determined VA's Program was not meeting its primary goal of ensuring that illegal drug use was eliminated to the extent feasible and VA's workplace was safe. The OIG testified at two recent hearings, and our written testimony highlights our findings in this area.[5]

Further, we are currently conducting a national audit of the VA's suitability adjudication program. We anticipate issuing our report in early calendar year 2018.

Question: According to the GAO report, some hospitals have appointed a Special Coordinator to oversee substance inspections, which seems to have improved outcomes. Is this something that could be applied system-wide? Are there any other "localized" best practices that you'd recommend be disseminated more widely? Have you made any other recommendations that are currently open that would help the VA improve its substance inspection programs?

Answer: The OIG has not performed work in this specific area, and so we are not able to comment on the effectiveness of this approach. In the past through our Combined Assessment Program reviews (CAP Reviews), we have analyzed pharmacy operations including environment of care, management of controlled substances, and pharmacy security. For example, we conducted a review during our fiscal year 2013 CAP Reviews to include 58 facilities and issued a summary of the results in June 2014.

The summary report contained 10 recommendations focused on opportunities for improvements:

- Conducting annual physical security surveys and correcting identified deficiencies

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[4] *Audit of VA's Drug-Free Workplace Program* (March 30, 2015)

[5] See *Statement of Nicholas Dahl, Deputy Assistant Inspector General for the Office of Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Assessing VA's Risks For Drug Diversion"* (February 27, 2017) and *Statement of Nicholas Dahl, Deputy Assistant Inspector General for the Office of Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs Before the Subcommittee on National Security, Committee on Oversight and Government Reform, United States House of Representatives, Hearing on "Assessing VA's Human Capital Management Risks"* (March 1, 2017).

- Completing controlled substances quarterly trend reports and providing them to facility Directors
- Conducting monthly controlled substances inspections of non-pharmacy areas
- Completing non-pharmacy controlled substances inspection activities
- Performing emergency drug cache quarterly controlled substances physical counts and monthly verification of seals
- Validating completion of required drug destruction activities
- Verifying 10 percent of outpatient pharmacy written prescriptions for Schedule II drugs
- Validating accountability of prescription pads stored in the pharmacy
- Defining policy for acceptable reasons for missed controlled substances area inspections
- Providing annual controlled substances inspectors training.

VA concurred with the recommendations and reported in December 2014 that action had been taken to address these recommendations.

Currently, we are working on a report that addresses VHA's pain management practices. In accordance with our findings, we will make any recommendations regarding substance inspection/monitoring as appropriate. The existing pharmacy directives and accountability requirements, if followed, should limit the ability for the theft or misuse of narcotic medications.

[Questions for the record submitted by Congressman Jenkins for the Honorable Michael J. Missal follows:]

Question: Under the Comprehensive Addiction and Recovery Act, the VA is required to disclose certain information to state controlled substance monitoring programs. Has the VA issued any guidance to the field specifically on prescription drug monitoring programs? And what is the role of the OIG to ensure those required to provide this information are in compliance?

Answer: VA issued Directive 1108.07, *Pharmacy General Requirements,* on March 10, 2017, which includes the requirement "to submit certain prescription data to states which allow VA to enroll in their Prescription Drug Monitoring Programs (PDMP)."[1] Further, VA issued Directive 1306, *Querying State Prescription Drug Monitoring Programs (PDMP)* on October 19, 2016, which requires "VHA health care providers to query state PDMPs to support safe and effective prescribing of controlled substances."[2]

The OIG has an ongoing review of VHA's Pain Management Services, which is scheduled to be published this year. This review will address aspects of the use of the PDMP databases by VA providers.

[1] VA Directive 1108.07, *Pharmacy General Requirements* (March 10, 2017).
[2] VA Directive 1306, *Querying State Prescription Drug Monitoring Programs (PDMP)* (October 19, 2016).

[Questions for the record submitted by Ranking Member Wasserman Schultz for the Honorable Michael J. Missal follows:]

Question: The FY 2017 enacted level represents the first of what the VA says will be a sustained series of appropriation increase requests to "right size" OIG staffing levels to an appropriate ratio given the size, scope, and complexity of the VA mission and organization. While we have no details on your FY 2018 request, we do know the VA is up 6% over last year. Is there anything you can share regarding your office?

Answer: OIG has received budget increases in recent years due to Congress' recognition of our required oversight work and significant contributions to improve the way VA operates. However, OIG's average growth had historically lagged behind VA's growth. Although the FY 2017 budget does move us closer to an organizational strength necessary to effectively oversee VA operations, OIG's funding level is still less than 0.1 percent of VA—well below funding ratios at comparably situated Federal OIGs. In consideration of the current fiscal climate and recent hiring challenges, OIG scaled back requirements for FY 2018 and is targeting an operational level of $170 million to support the second phase of our "right sizing" effort. We intend to pursue a tiered expansion over the near term that will support upwards of 1,160 FTE by 2021.

Question: For a Department the size of the VA what should the funding level for your office be and how many more staff would you need to conduct proper oversight?

Answer: OIG's growth plan is to develop to an onboard employee strength of 1,160 FTE based on a $234 million appropriation by FY 2021. Any faster rate of growth would be challenging to support given the need for appropriate employee selection, training, and space considerations. Our FY 2017 appropriation of $160 million is 0.09 percent of VA's $182 billion budget. Even if VA's funding were to remain constant at FY 2017 levels, an OIG budget of $234 million would still only raise OIG's percentage as a function of VA's budget to 0.13 percent. Although this increase over the course of the next four FYs would still place VA OIG near the bottom in comparison to how other OIGs measure against their parent agencies, it would be a step in the right direction for sustained longer term growth for our organization.

Question: The OIG released a report earlier this week on caller response and quality assurance concerns within the Veteran Crisis Line. This inspection substantiated allegations that the national call centers at Canandaigua and Atlanta were routing some calls to back up call centers. How often did this happen?

Answer: During the period of our review (June–December 2016), the VCL routed calls to backup centers approximately 25–30 percent of the time. Page 18 of our report provides additional details on this topic.[1]

Question: What is the difference between a call answered at the main center, which is already technically a backup for the local mental health hotlines, and a call answered at backup center?

Answer: The VCL is the main crisis line for VA. It is not a backup to local crisis lines. Veterans are routed to the VCL after calling the National Suicide Prevention Line phone number and responding to a prompt that states, "Veterans Press 1." Calls reaching the VCL are load balanced between Canandaigua and Atlanta. This means the call will be answered by the first available responder at either site. If a caller does not press 1 when prompted, they will be routed to one of the many crisis lines that are part of the National Suicide Prevention Line network but not the VCL and probably not one of the VCL's backup centers. The backup centers that the VCL used during the period of our review functioned for the VCL with calls that exceeded the VCL capacity. When the VCL could not answer within 30 seconds (at either the Canandaigua or Atlanta locations) the call would roll to one of the 4 backup centers.

Question: The IG report also referenced cited training issues, a lack of structured leadership and little follow-through on making improvements the inspector general recommended last year. How many recommendations were made in the last report and how many did the VA follow?

Answer: The OIG report from February 2016 made seven recommendations. VA concurred with all seven recommendations and submitted actions plans to be completed by September 2016.[2] However, at the time of the publication of our March 20, 2017 report, all seven recommendations from the 2016 report remained open. VHA submitted information to the OIG on March 27, 2017 and requested closure on six of the seven recommendations. We are in the process of analyzing the information to determine if VA has demonstrated sufficient implementation action to warrant closure of the six recommendations.

Question: Is the training the same across VA or do the training at main call centers differ from those at the backup call centers? And differ from those at local VA centers?

Answer: While VCL staff members communicate with VA facilities through local Suicide Prevention Coordinators, VCL is an independent entity without parallel call centers or programs at VA medical centers. Therefore, there are no comparative training standards. The VCL standards for training have been set by VCL staff in leadership positions, and the VCL is accredited by the American Association of

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[1] *Healthcare Inspection - Evaluation of the Veterans Health Administration Veterans Crisis Line*, March 20, 2017

[2] *Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York*, February 11, 2016.

Suicidology. Page 25 of our 2017 report notes some training differences about ratios of learners to preceptors, which were higher in Atlanta than in Canandaigua. The backup centers are not trained by VA. Backup centers' staff is provided some veteran and military specific information by VA for problems sometimes associated with time serving in the armed services. However, the training is provided by the contractor and is not verified by VA.

Question: As you know, the Atlanta facility was established in order to have zero calls rollover to backup centers. The VA has been unable to achieve this objective. Was this goal realistic?

Answer: As our 2017 report notes, the Atlanta Call Center accepted its first call on October 10, 2016, but did not meet its primary target date of zero rollover calls to backup call centers by November 21, 2016, or by its secondary target date of December 12, 2016. We initiated our review in June 6, 2016 and completed work on December 15, 2016. As you are aware, VA issued a press release shortly after our 2017 report was published stating that the rollover rate is at 1 percent or less. However, the OIG has not independently verified this statement and we did not offer an opinion on the goal.

Question: In FY 2017, the VA was provided $78.6 million for the VCL, if this amount is insufficient have you identified a proper funding level?

Answer: Our healthcare inspection did not specifically analyze adequacy of current or future funding. Page 6 of our 2017 report displays a funding versus volume table illustrating the growth of both funding and volume of work to the VCL.

Question: Additionally, according to the report some VCL employees told the inspector general's office that the emphasis at the Veterans Crisis Line was on business metrics, rather than tracking whether veterans received the help they needed. Does the VA track the veterans that used the hotline?

Answer: VCL Social Service Assistants contact local suicide prevention coordinators when a rescue is initiated and follow up to ensure that the veteran has been contacted by the Suicide Prevention Coordinator. Otherwise, the VCL did not track outcomes of veterans post-VCL contact at the time of our review. Please note that some veteran contacts are anonymous and some veterans ask the VCL staff not to contact the local VA medical center.

Question: A recent IG report found that veterans are still waiting months for appointments made through the Choice Program, the very problem the Choice Program was supposed to end, can you explain what is happening?

Answer: In VISN 6, we found that veterans waited months for care under the Veterans Choice Program (Choice) for the period of our review which was October 2015 through December 2015. This was primarily because of the amount of time it took medical

facility staff to provide the authorization to Health Net to begin the Choice process in addition to the amount of time it took Health Net to provide the service. These issues occurred primarily because staffing resources were not sufficient to effectively manage the increased Non-VA Care Coordination (NVCC) workload. This increased workload includes the need to manually review each NVCC authorization to determine whether it had been provided to Health Net, and, if so, determine whether an appropriate appointment had been scheduled or completed.

We found another contributing factor to be that Health Net usually did not create Choice appointments in a timely manner. Although VA's Choice contract required Health Net to create an appointment for the veteran within 5 business days of receiving the authorization, we estimated appointments were created more than 5 business days after they received the authorization for nearly three out of every four appointments. Further, when VA provided Health Net with an authorization with a clinically indicated date, we estimated that about two-thirds of veterans did not receive the Choice appointment within 30 days of that clinically indicated date, as required by the contract.

Question: According to the report, veterans are waiting on average of 84 days to get care through Health Net. It was estimated it that it took medical facility staff an average of 42 days to provide the authorization to Health Net to begin the Choice process and 42 days for Health Net to provide the service. This question has two parts, first why is it taking VA 42 days to provide authorization and second why is it taking Health Net 42 more days after the authorization?

Answer: Since VA implemented Choice in November 2014, VISN 6 non-VA care work requirements have increased by over 200 percent. Facility non-VA care coordination staff process non-VA care authorizations; manage the Veterans Choice List and Choice consults; create Health Net authorizations; and process Health Net returns, which require facility staff to resubmit the authorization or find care in the community through traditional non-VA care processes. We found that due to the significant increase in the work requirements and limited additions of non-VA care coordination staff for most of the VISN 6 medical facilities, each VISN 6 non-VA care full-time equivalent would have to address over twice as many work requirements than in FY 2014. In addition, non-VA care coordination staff could not adequately monitor Health Net's portal to ensure veterans received timely care and ensure Health Net timely returned authorizations in compliance with contract requirements. Staff must manually review each active authorization to determine if the authorization had been provided to Health Net, and if so, they must then monitor Health Net's portal to determine the status of each Health Net authorization until the appointment information is updated.

Regarding Health Net delays, we estimated appointments were created more than 5 business days after Health Net received the authorization for about 73 percent of appointments. VA changed the contract after our audit period (change effective June 1, 2016) to require authorizations be returned to VA after 5 business days for routine care in an attempt to improve Health Net's timeliness. Additionally, the contract required the contractor to provide the Choice care appointment within 30 days of the clinically

indicated date, and we estimated that VA facility staff did not provide a clinically indicated date to Health Net for about 41 percent of authorizations. If VA does not provide a clinically indicated date as required by the contract, it cannot enforce compliance with the 30-day requirement. For those authorizations in which VA did provide a clinically indicated date, we estimated that 66 percent of veterans did not receive the Choice appointment within 30 days.

Question: There have been numerous issues about Health Net poor performance in ensuring local veterans get timely access to care in under 30 days. Obviously Health Net is performing poorly. When the program expires I assume the contract with Health Net would end?

Answer: Currently, the Office of Community Care (OCC) has a request for proposal to replace the existing Patient-Centered Community Care/Choice contracts with TriWest and Health Net. This effort has been ongoing for an extended period and we do not have firm date as to when OCC plans to solicit bids and award a new contract. However, it is unlikely at this juncture that a new contract will be awarded by the end of FY 2017. Question 14 would be best directed to VA.

Question: What would happen with Health Net and Tri-West as well if the Choice program is extended?

Answer: Please see our response to Question 13. This question would be best directed to VA.

Question: Another issue I find perplexing is that the IG found that the VA did not have adequate resources to ensure the program was meeting its required targets. I find this odd because the program was $15 billion with part of it being for infrastructure and the other part being for care. Right now the Choice program [is] on track to hit its expiration date with money left over ($750 million). So how is it possible that this program did not have adequate resources?

Answer: During our audit of VISN 6, we determined that delays in Choice care were caused, in part, by insufficient non-VA care coordination staffing by the VISN 6 medical facilities. As of July 2016, we calculated that due to the significant increase in the non-VA care workload and limited additions of those staff for most of the VISN 6 medical facilities, each full-time equivalent staff member would have to address over twice as many work requirements than in FY 2014. VA agreed that staffing levels have not always matched the workload requirements in the Choice Program in VISN 6, and stated that staffing levels have since increased within VHA's facilities. Without accurate wait time data, VHA and VISN 6 leadership did not have the information needed to identify and resolve potential access to care issues or to justify the need for additional resources.

Question: One more troubling aspect is that the IG report also noted that investigators found a significantly higher number of patients who had to wait longer than 30 days to

be seen than what data in the VA's system showed for wait times. The VA's own data showed just ten percent of veterans had experienced extended wait times. Do you believe that the VA is still manipulating wait time data?

Answer: The longer wait times we identified than what VA systems showed occurred primarily because VISN 6 and medical facility management did not ensure staff consistently complied with VHA's scheduling requirements. Until July 2016, VHA had not updated their scheduling policy and instead provided periodic guidance through memos and training materials. According to VA, in order to assist leaders and managers in complying with scheduling policy, they created the Scheduling Trigger Tool to oversee scheduling compliance. This tool combines data from individual access measures in order to uncover issues with scheduling practices at all VA facilities. The trigger tool scores VAMCs on Data Integrity and Scheduling Compliance, and signal potential changes in scheduling practices that can impact clinic wait times.

[Questions for the record submitted by Congressman Bishop for the Honorable Michael J. Missal follows:]

Question: It is critical that we put measures in place to protect sensitive information and defend against those who seek to gain unauthorized access to that information. The VA has an obligation to safeguard the data we hold on Veterans, and I know that everyone takes that responsibility seriously. However, in your statement, aspects of VA IT security have been continually reported as a material weakness for 17 years. From my understanding, your latest information security audit, you recommended 35 actions that would improve the information security program. How many have been implemented? What is your current assessment of the VA's vulnerability against a cyber-attack and the ability to respond effectively to a successful attack?

Answer: Our FY 2015 report provides 35 total recommendations for improving VA's information security program. VA successfully closed four recommendations and we identified six new recommendations in FY 2015. VA has made progress developing policies and procedures as part of its information security program. However, it still faces challenges implementing components of its agency-wide information security risk management program to meet Federal Information Security Modernization Act (FISMA) requirements. Our FY 2016 FISMA report is expected to be released in June 2017.

While some improvements were noted, the FY 2015 FISMA audit continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems. Weaknesses in access and configuration management controls resulted from VA not fully implementing security standards on all servers, databases, and network devices. VA also has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, database, and server platforms VA-wide. Further, VA has not remediated approximately 9,500 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its information security posture. As a result, the FY 2015 consolidated financial statement audit concluded that a material weakness still exists in VA's information security program.

In FY 2015, the VA's Chief Information Officer formed an Enterprise Cybersecurity Strategy team charged with delivering an enterprise cybersecurity strategic plan. The plan was designed to help VA achieve transparency and accountability while securing veteran information. The agency submitted an enterprise cybersecurity strategy to Congress on September 28, 2015—ahead of schedule. VA did not monitor all external interconnections and internal network segments for malicious traffic or unauthorized systems access attempts. More specifically, some local facilities had stopped VA's Network and Security Operations Center from periodically testing certain systems for security vulnerabilities. Consequently, the Network and Security Operations Center did not have a complete inventory of all locally hosted systems and must rely on local sites to identify systems for testing. Ineffective monitoring of internal network segments could

block VA from detecting and responding to intrusion attempts in a timely manner. We continued to identify numerous high-risk cyber security incidents, including malware infections that were not remedied in a timely manner. Specifically, we noted a high number of malware security incident tickets that took more than 30 days to remedy and close. While VA's performance improved from the prior year, the process for tracking higher risk incident tickets remained inefficient for a large portion of FY 2015, and some cyber security incidents were not remedied.

Question: After reviewing the 2016 Advisory Committee report on Minority Veterans, I am concerned that the VA does not consistently collect race and ethnicity data. According to the Center for Minority Veterans, by 2040, minority veterans are projected to represent over a third of all veterans despite overall Veteran population decreases. This is information that could be used to suggest policy reforms and recommendations to address the needs of an increasing minority Veteran population – to include health disparities, academic affiliations, and unconscious bias in hiring practices that may lead to a lack of diversity, specifically at the senior management level. Do you have any planned or recent audits, inspections, or evaluation that focus on minority Veterans? Women Veterans? If so, what are some of your recommendations? How many remain open?

Answer: Currently, the OIG does not have any ongoing work focused on minority veterans. The OIG has access to VA data sets that provide information on the sex, race, and/or ethnicity of veterans. However, there are issues with the accuracy of this data, as definitions of race and ethnicity are sometimes not clear. Therefore, if the analysis of issues under review provides a list of veterans, OIG is able to link that list of identified veterans with tables that contain other information about the veteran, to include sex and race or ethnicity. This requires that each veteran in the list is uniquely identified through a social security number, date of birth, etc.

The OIG has provided specific oversight to women's issues. We conducted two national reviews in 2010 and 2012 related specifically to women veterans.[1] One reviewed services available to women veterans who had experienced military sexual trauma (MST) and the other assessed women veterans' use of VA health care for traumatic brain injury, post-traumatic stress disorder, and other mental health conditions and whether the Veterans Benefits Administration (VBA) properly adjudicated women veterans' disability claims for these conditions. Additionally, since 2010, the OIG has reviewed various aspects of women's health care provided by VA in our cyclical Community Based Outpatient Clinic (CBOC) reviews resulting in dozens of facility-specific reports and recommendations and three summary reports. Our CBOC reviews have reviewed such areas as privacy and security of the health care environment, the timeliness of breast and cervical cancer screening, and the proficiency of designated women's health providers (DWHP) in the core concepts of women's health, among others. We provide an appendix of OIG work and summarized many of our findings in

[1] *Healthcare Inspection - Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma* (December 5, 2012) and *Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits* (December 16, 2010).

written testimony submitted for a 2015 hearing on women's health.[2] All recommendations made in these reports have been implemented.

The CHIP program, the updated version of the medical center inspection program, will also continue to include oversight of women's health issues in the inspection program. Of our women-focused reviews that are currently ongoing, one will examine VA's ability to provide gender-specific care for women veterans and assess the efficacy of and compliance with privacy standards. Additionally, we remain interested in MST related issues and have plans to publish on this topic over the next 18 months. We will issue reports when our work is complete, and we will brief Members of Congress who have expressed an interest in these topics. The OIG will continue to evaluate aspects of women's healthcare on a regular basis.

Question: Your audit report found that the VA made about $247 million in improper G.I. Bill payments and $205 million in missed recoupments annually. On 17 March 2017, last Friday evening the VBA website posted a message stating that Veterans and service members can expect processing delays due to an internal audit. When do you expect the audit will be completed? How many current G.I. bill claims are currently backlogged? When will the VBA be able to start working through the growing G.I. Bill backlog?

Answer: The message in question was posted on a VA website maintained by VBA and appears to refer to an internal review initiated by VBA. Questions related to this matter should be directed to VBA.

Question: Last week, as you may be aware, the House of Representatives unanimously passed legislation (the VA Accountability of Physicians Hiring Act) designed to speed up the hiring of physicians and nurses at the Department of Veterans Affairs. However, the bill did not call for any measures that would provide oversight to ensure that the VA prudently applies recruitment, relocation, and retention incentives. In your statement, you highlighted that the VA's controls of these pay authorities as a concern. Have you provided any recommendations in this area to the VA? If so, have they executed them?

Answer: The table below lists the 10 recommendations made in our report.[3] The Assistant Secretary for Human Resources and Administration's planned corrective actions are responsive to our report recommendations. Based on the corrective actions already implemented in response to Recommendations 2, 4, and 8, we consider these recommendations closed. We will monitor the Office of Human Resources and Administration's implementation of the remaining recommendations until all proposed actions are completed.

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[2] See *Statement of the Office Of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Examining Access And Quality Of Care and Services for Women Veterans.* (April 30, 2015)

[3] *Audit of VA's Recruitment, Relocation, and Retention Incentives* (January 5, 2017).

Recommendation	Status
1. We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to ensure recruitment and relocation incentives are fully justified and authorized before being included on vacancy announcements for hard-to-fill positions or before the final selectee is identified in cases where a position is not filled through a vacancy announcement.	Open
2. We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for the Corporate Senior Executive Management Office to ensure Senior Executive Service recruitment and relocation incentives are fully justified and authorized before being included on vacancy announcements for hard-to-fill positions or before the final selectee is identified in cases where a position is not filled through a vacancy announcement.	Closed
3. We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor compliance with its employee certification requirement before relocation incentives are authorized for payment.	Open
4. We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls to monitor the Corporate Senior Executive Management Office's compliance with the employee certification requirement before Senior Executive Service relocation incentives are authorized for payment.	Closed
5. We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor facilities' compliance with developing workforce and succession plans to reduce the risk of long-term reliance on retention incentives.	Open
6. We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls to monitor the Corporate Senior Executive Management Office's compliance with developing workforce and succession plans to reduce the risk of long-term reliance on retention incentives for Senior Executives.	Open

7. We recommended the Assistant Secretary for Human Resources and Administration monitor the Corporate Senior Executive Management Office to ensure its technical review and recommendations to the VA Chief of Staff regarding Senior Executive Service incentives are prudent and in full compliance with VA Handbook 5007/46.	Open
8. We recommended the Assistant Secretary for Human Resources and Administration assess the feasibility of limiting the number of consecutive years employees in specific occupations or groups of employees in specific occupations can receive retention incentive payments.	Closed
9. We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor facilities' compliance with VA Handbook 5007/46 requirements to initiate debt collection from individuals who did not fulfill their recruitment, relocation, or retention incentive service obligations.	Open
10. We recommended the Assistant Secretary for Human Resources and Administration examine the capabilities of the HR Smart personnel system to determine the extent to which it is possible to develop an incentive-specific automated alert that notifies Human Resources personnel when employees have outstanding recruitment, relocation, or retention incentive service obligations.	Open

Question: Mr. Missal, it's critical that information and data collection related to access to care needs is current, accurate, and available to help VA address the significant challenges in the delivery of health services under the Choice program. According to your statement, there are many instances when schedulers have manipulated dates to make it appear that appointment wait times were less than 30 days. Have you made any recommendations to the Department regarding data quality and reliability? If so, what is the status of that recommendation?

Answer: The table below lists recent OIG reports containing recommendations regarding data quality and reliability issues. Please note that these reports may contain additional recommendations unrelated to data quality and reliability that are omitted in the table below.

Report/Issue(s)	Recommendation	Status
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6 (March 2, 2017) Issues: • Inaccurate wait time data • Eligible veterans were not added to the Veterans Choice List	1. We recommended the Under Secretary for Health establish a method to monitor and ensure Veterans Integrated Service Network compliance with scheduling requirements.	Open
	2. We recommended the director of Veterans Integrated Service Network 6 ensure that staff at all VA medical facilities use the referring provider's clinically indicated date, when available, or documented veteran's preferred appointment date, when scheduling new patient appointments.	Open
	3. We recommended the director of Veterans Integrated Service Network 6 ensure VA medical facilities conduct required scheduler audits and take corrective actions as needed based on audit results.	Open
Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas (June 20, 2016)	4. We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center improves scheduling audit processes to ensure that managers conduct a complete review of appointment data to ensure scheduling staff are using the correct	Open

Issue: Inaccurate wait time data	cancellation type and clinically indicated or preferred appointment date.	
	5. We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center makes sure managers take corrective action when audits identify deficiencies in scheduling staff's use of appointment cancellation type and clinically indicated or preferred appointment dates.	Closed
	6. We recommended the Veterans Integrated Service Network 16 Director conduct a scheduling audit within 3 months after Recommendations 3 through 5 are implemented to ensure the corrective actions taken were effective.	Closed
Review of Alleged Untimely Care at the Community Based Outpatient Clinic, Colorado Springs, Colorado (February 4, 2016) Issues: • Inaccurate wait time data • Eligible veterans were not added to the Veterans Choice List	1. We recommended the Eastern Colorado Health Care System Director ensure that scheduling staff use the clinically indicated or preferred appointment dates when scheduling primary care patient appointments.	Closed
	3. We recommended the Eastern Colorado Health Care System Director ensure that staff place all veterans with appointments occurring over 30 days after the clinically indicated or preferred appointment date on the Veterans Choice List within 1 day of scheduling the appointment.	Closed

[Questions for the record submitted by Congresswoman Lee for the Honorable Michael J. Missal follows:]

Question: Is the OIG is currently capable of reporting findings by race and ethnicity in its usual course of business, where relevant? For example, when examining average wait time to see a doctor, or average wait time in the ER, is your office able to report data disaggregated by race and ethnicity?

Answer: The OIG has access to VA data sets that provide information on the sex, race, and/or ethnicity of veterans. However, there are issues with the accuracy of this data, as definitions of race and ethnicity are sometimes not clear. Therefore, if the analysis of issues under review provides a list of veterans, VA is able to link that list of identified veterans with tables that contain other information about the veteran, to include sex and race or ethnicity. This requires that each veteran in the list is uniquely identified through a social security number, date of birth, etc.

Question: As I understand it, we have seen a steady reduction in the backlogged claims, but I'm concerned from the case work we are seeing in my district office that while claims are being processed more expeditiously, the increase in appeals that these claims generate is too much for the current system to sustain. You mentioned in your testimony that VBA's "aggressive focus on reducing the backlog of compensation claims occurred at the expense of delaying the processing" of other work like appealed claims.

Would you please elaborate your views on this issue and let us know what kinds of investigations OIG has been doing to address the appeals workload? What is the backlog of appealed claims originating from the Oakland VARO?

Answer: Since 2014, we have noted in our annual report of VA's Major Management Challenges, which accompany VA's annual Agency Financial Report (formerly known as the Performance and Accountability Report) our concern over the increased appeals inventory resulting from VBA's focus on eliminating the claims processing backlog. To that end, the OIG is conducting a review of the Veterans Benefits Administration's (VBA) appeals process. We are conducting this review to determine whether opportunities exist for VBA staff to improve the timeliness of appeals processing. This review focuses on appeals in several different phases where VBA is required to take action after receipt of a Notice of Disagreement (NOD), a substantive appeal, or a Board of Veterans' Appeals decision. We are assessing whether VBA staff complied with appeals processing policies and procedures, specifically focusing on those affecting timeliness. Currently, VBA has not provided a definition of backlogged appeals. Additionally, over the course of time VBA has removed appeals timeliness goals from the VBA Directors Performance Dashboard, which is a tool used to track and measure how well VA regional offices (VARO) are performing. Measurements that were removed included timeliness of NODs and substantive appeals.

Question: regarding the Oakland VARO's workload/backlog should be directed to VA.

Question: What steps do you recommend for the VA to take to address this issue?

Answer: While we have not reviewed appeals processing at the Oakland VARO specifically, we will certainly issue recommendations in our national report on this topic.

WEDNESDAY, MARCH 29, 2017.

PUBLIC WITNESSES HEARING

CHAIRMAN DENT OPENING STATEMENT

Mr. DENT [presiding]. Good morning. I would like to bring to order this hearing of the House Subcommittee on Military Construction and Veterans Affairs. Today we are going to take testimony from public witnesses to hear the views of their organizations on matters related to this subcommittee's jurisdiction.

We welcome you all here this morning.

And I am happy to say that we were able to accommodate all the witnesses who wished to testify regarding the fiscal year 2018 appropriations and oversight matters for MILCON–VA. As it turns out, all the witnesses are commenting on VA issues.

I wanted to note that there are multiple appropriations hearings today at 10 o'clock, so several subcommittee members have conflicts and may not be able to join us or will be here intermittently.

We will also be sure to share your views with them and with the committee as a whole. So again, thank you for being here.

For public witnesses hearings we move quickly to accommodate everyone. Each witness will have 5 minutes to testify. I would not expect many questions, but if there are any from members please try to answer them as briefly as you can.

The full written testimony that each of you submitted will be entered into the official record.

With that said, we appreciate that you have taken time to share your expertise and viewpoints on current and future veterans affairs issues with the committee and look forward to a valuable meaningful discussion this morning.

Let me turn to the ranking member of our subcommittee, Ms. Wasserman Schultz, for any remarks that she may have. I recognize the gentlelady from Florida.

RANKING MEMBER WASSERMAN SCHULTZ OPENING STATEMENT

Ms. WASSERMAN SCHULTZ. Thank you so much, Mr. Chairman, for yielding, and I appreciate you agreeing to hold this important public witness hearing.

Today's witnesses work tirelessly to assist our veterans daily as they navigate the—as I have been increasingly discovering—too often cumbersome VA system; the transition to civilian life; and the physical, emotional, psychological, and financial challenges that our veterans face upon returning home. To best identify the needs of our veterans it is important that we hear from them and partner with those who know them best, our VSOs.

While the VA has made great strides in recent years, we know our work is far from done. This type of hearing is vital for us as

appropriators and provides the opportunity to zero in on the issues the American public and the veterans community rely on this committee to address, particularly as we approach our process of marking up our bill.

So thank you all for joining us today, and also thank you for joining us yesterday at Leader Pelosi's VSO roundtable. I look forward to participating in that going forward as well as hearing your testimony this morning.

Thank you. Yield back.

Mr. DENT. Thank you.

Thank the gentlelady from Florida.

At this time I would like to ask Mr. Blake to please take the seat. Mr. Blake is the associate executive government relations with the Paralyzed Veterans of America.

Thank you for joining us, and you are recognized for 5 minutes.

WEDNESDAY, MARCH 29, 2017.

PARALYZED VETERANS OF AMERICA

WITNESS

CARL BLAKE, ASSOCIATE DIRECTOR OF GOVERNMENT RELATIONS

Mr. BLAKE. Thank you, Mr. Chairman, Ranking Member Wasserman Schultz. I appreciate the opportunity to be here today.

Let me first say that we are pleased to be able to have this opportunity once again. This used to be a regular occurrence with this subcommittee, having the VSOs come before you as outside witnesses, but that hasn't happened in a number of years and we are pleased to have that opportunity once again. We find this exchange very important.

I am here on behalf of Paralyzed Veterans of America, as well as my partners in The Independent Budget, Disabled American Veterans, and Veterans of Foreign Wars, who will also be testifying before you this morning. We will be discussing various aspects of the Department of Veterans Affairs funding for fiscal year 2018, as well as advance appropriations for fiscal year 2019.

This is our annual budget report that we have drafted. It outlines our recommendations in detail about all of the funding requirements of VA.

With the chairman's indulgence, we would like to submit this into the official hearing record?

[The information follows:]

The Independent Budget

for the Department of Veterans Affairs

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Budget Recommendations for FY 2018 and FY 2019

Introduction

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

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

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

The IBVSOs are jointly releasing this stand-alone report that focuses solely on the budget for VA and our projections for VA's funding needs across all programs. This report is not meant to suggest that these are the absolute correct answers for funding these services. 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 continuous funding deficits.

Our recommendations include funding for all discretionary programs for FY 2018 as well as advance appropriations recommendations for medical care accounts for FY 2019. The FY 2018 projections are particularly important because previous VA Secretary Robert McDonald admitted last year that the VA's FY 2018 advance appropriation request was not truly sufficient and would need significant additional resources provided this year. We hope that Congress will take this defined shortfall very seriously and appropriately address this need. Our own FY 2018 estimates affirm this need.

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

VA Accounts for FY 2018 and FY 2019 Advance Appropriations

	FY 2017 Appropriation	FY 2018 Admin	FY 2018 IB	FY 2019 Adv Approp	FY 2019 IB Adv Approp
Veterans Health Administration (VHA)					
Medical Services	45,505,812	44,886,554	64,493,555		69,450,838
Medical Community Care	7,246,181	9,409,118			
Choice Program*	2,900,000				
Subtotal Medical Services	55,651,993	54,295,672	64,493,555		69,450,838
Medical Support and Compliance	6,524,000	6,654,480	6,657,955		6,793,408
Medical Facilities	5,321,668	5,434,880	5,796,343		6,562,579
Subtotal Medical Care, Discretionary	**67,497,661**	**66,385,032**	**76,947,853**		**82,806,825**
Medical Care Collections	*3,558,307*	*3,627,255*			
Total, Medical Care Budget Authority (including Collections)	***71,055,968***	***70,012,287***	***76,947,853***		***82,806,825***
Medical and Prosthetic Research	675,366		713,200		
Million Veteran Program			65,000		
Total, Veterans Health Administration	**71,731,334**	**70,012,287**	**77,726,053**		
General Operating Expenses (GOE)					
Veterans Benefits Administration	2,856,160		3,134,540		
General Administration	345,391		406,454		
Board of Veterans Appeals	156,096		158,196		
Total, General Operating Expenses (GOE)	**3,357,647**		**3,699,190**		
Departmental Admin and Misc. Programs					
Information Technology	4,278,259		4,361,502		
National Cemetery Administration	286,193		291,085		
Office of Inspector General	160,106		162,545		
Total, Dept. Admin. and Misc. Programs	**4,724,558**		**4,815,132**		
Construction Programs					
Construction, Major	528,110		1,500,000		
Construction, Minor	372,069		700,000		
Grants for State Extended Care Facilities	90,000		300,000		
Grants for State Vets Cemeteries	45,000		46,000		
Total, Construction Programs	**1,035,179**		**2,546,000**		
Other Discretionary	201,000		203,000		
Total, Discretionary Budget Authority (Including Medical Collections)	***81,049,718***		***88,989,375***		

*The Administration's FY 2017 revised budget request initially assumed approximately $5.7 billion in resource expenditures from the Choice program. More recent estimates from VA indicate about $2.9 billion in resource expenditures from the Choice program in FY 2017 increasing the total Medical Services expenditure for FY 2017, including Medical Care Collections, to nearly $59.2 billion.

Veterans Health Administration

Total Medical Care

FY 2018 *IB* Recommendation	**$77.0 billion**
FY 2018 Revised Administration Request	
FY 2018 Enacted Advance Appropriations	**$66.4 billion**
Medical Care Collections	***$3.6 billion***
Total	**$70.0 billion**
FY 2019 *IB* Advance Appropriations Recommendation	**$82.8 billion**
FY 2019 Administration Advance Appropriations Request	
Medical Care Collections	
Total	

The IBVSOs have serious concerns about the FY 2018 advance appropriations requested by the previous Administration and subsequently approved by Congress. Last year, the former Secretary of Veterans Affairs openly admitted that the FY 2018 advance appropriations request was significantly short. He also indicated that the new Administration and Congress would have to correct this shortfall. We are concerned that this new Administration has not yet indicated its desire to correct this problem before it has catastrophic consequences for the VA. If the new Administration's budget request fails to properly address this issue, it is imperative that Congress takes necessary action to properly resource the VA health care system.

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

For FY 2018, the *IB* recommends approximately $77.0 billion in total medical care funding. Congress previously approved only $70.0 billion for this account for FY 2018 (which includes an assumption of approximately $3.6 billion in medical care collections). The *IB's* recommendation also considers the approximately $1 billion VA is expected to have remaining in the Veterans Choice Fund and expected demand for care, including community care, that will not diminish or go away if the Choice Program expires.

Additionally, *The Independent Budget* recommends approximately $82.8 billion for total Medical Care for FY 2019. This recommendation reflects the necessary adjustment to the baseline for all Medical Care program funding in the preceding fiscal years.

Medical Services

Appropriations for FY 2018

FY 2018 *IB* Recommendation	**$64.5 billion**
FY 2018 Revised Administration Request	
Medical Care Collections	***$3.6 billion***
Subtotal	
FY 2018 Enacted Advance Appropriations	**$54.3 billion**
Medical Care Collections	***$3.6 billion***
Subtotal	**$57.9 billion**

For FY 2018, *The Independent Budget* recommends $64.5 billion for Medical Services. This recommendation is a reflection of multiple components. These components include the following recommendations:

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

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate also assumes a 1.5 percent increase for pay and benefits across the board for all VA employees in FY 2018.

Our estimate of growth in patient workload is based on a projected increase of approximately 90,000 new unique patients. These patients include priority group 1–8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately $1.4 billion. The increase in patient workload also includes a projected increase of 58,000 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) enrollees, as well as Operation New Dawn (OND) veterans at a cost of approximately $242 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users through the third quarter of FY 2016.

The Independent Budget believes that there are additional projected medical program funding needs for VA. Those costs total approximately $2.0 billion. 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 and Sensory Aids Service); funding to expand and improve services for women veterans; funding to support the recently approved authority for reproductive services, to include in vitro fertilization (IVF); and funding to allow VA to MEET the building costs for emergency care as dictated by the Staab court ruling.

Long-Term Services and Supports

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

Prosthetics and Sensory Aids

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

Women Veterans

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

Reproductive Services (to Include IVF)

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

Emergency Care

Recently, the VA has received serious scrutiny for its interpretation of legislation dating back to 2009, which required it to pay for veterans who sought emergency care outside of the VA health care system. The *Richard W. Staab v. Robert A. McDonald* ruling handed down by the US Court of Appeals for Veterans Claims last year, places the financial responsibility of these emergency

care claims squarely on the VA. Although VA continues to appeal this decision, it is not expected to prevail in this case leaving itself with a more than $10 billion dollar obligation over the next 10 years. The Staab ruling is estimated to cost VA approximately $1.0 billion in FY 2018 and about $1.1 billion in FY 2019, which the *IB* has included in our recommendations..

Advance Appropriations for FY 2019

FY 2019 *IB* Advance Appropriations Recommendation	**$69.5 billion**
FY 2019 Administration Advance Appropriations Request	
Medical Care Collections	
Subtotal	

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

For FY 2019, *The Independent Budget* recommends approximately $69.5 billion for Medical Services. Our Medical Services level includes the following recommendations:

Current Services Estimate	$66,334,946,000
Increase in Patient Workload	$1,589,892,000
Additional Medical Care Program Cost	$1,526,000,000
Total FY 2017 Medical Services	$69,450,838,000

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

Last, as previously discussed, the IBVSOs believe that there are additional medical program funding needs for VA. In order to meet the increase in demand for prosthetics, the *IB* recommends an additional $330 million, reflecting the ever-growing cost of more advanced prosthetics being prescribed for seriously disabled veterans. We believe that VA should invest a minimum of $120 million as an advance appropriation in FY 2019 to expand and improve access to women veterans' health care programs. Our additional program cost recommendation includes continued investment of $20 million to support extension of the authority to provide reproductive

services to the most catastrophically disabled veterans. Finally, VA's cost burden for finally paying emergency care claims dictated by the Staab ruling exceeds $10.0 billion over 10 years and will require at least $1.1 billion in FY 2019 alone.

Medical Support and Compliance

FY 2018 *IB* Recommendation	**$6.658 billion**
FY 2018 Revised Administration Request	
FY 2018 Enacted Advance Appropriations	**$6.654 billion**
FY 2019 *IB* Advance Appropriations Recommendation	**$6.793 billion**
FY 2019 Administration Advance Appropriations Request	

For Medical Support and Compliance, *The Independent Budget* recommends $6.7 billion for FY 2018. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2017 appropriated level. Additionally, for FY 2019 *The Independent Budget* recommends $6.8 billion for Medical Support and Compliance. This amount also reflects an increase in current services from the FY 2018 advance appropriations level.

Medical Facilities

FY 2018 *IB* Recommendation	**$5.796 billion**
FY 2018 Revised Administration Request	
FY 2018 Enacted Advance Appropriations	**$5.435 billion**
FY 2019 *IB* Advance Appropriations Recommendation	**$6.563 billion**
FY 2019 Administration Advance Appropriations Request	

For Medical Facilities, *The Independent Budget* recommends $5.8 billion for FY 2018, nearly $400 million more than the enacted advance appropriation. Our Medical Facilities recommendation includes $1.35 billion for Non-Recurring Maintenance (NRM). The Administration's request over the past two budget cycles represented a wholly inadequate level for NRM funding, particularly in light of the actual expenditures that were outlined in the budget justification. While VA has actually spent on average approximately $1.3 billion yearly for NRM, the Administration has requested on average only $460 million for NRM. This request level is clearly insufficient. This decision means that VA is forced to divert funds programmed for other purposes to meet this need. While the VA's projected NRM expenditure for FY 2018 is higher than in years past, it still remains insufficient.

The Independent Budget recommends approximately $6.6 billion for Medical Facilities for FY 2019. Our FY 2019 advance appropriation recommendation also includes $1.35 billion for NRM. Last year the Administration's recommendation for NRM reflected a projection that would place

the long-term viability of the health care system in serious jeopardy. This deficit must be addressed.

Medical and Prosthetic Research

FY 2018 *IB* Recommendation	**$713 million**
Million Veteran Program	**$65 million**
Total IB Medical and Prosthetic Research	**$778 million**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$675 million**

The VA Medical and Prosthetic Research program is widely acknowledged as a success on many levels, and contributes directly to improved care for veterans and an elevated standard of care for all Americans. The research program is an important tool in VA's recruitment and retention of health care professionals and clinician-scientists to serve our nation's veterans. By fostering a spirit of research and innovation within the VA medical care system, the VA research program ensures that our veterans are provided state-of-the-art medical care.

Investing Taxpayers' Dollars Wisely

Despite documented success of VA investigators across many fields, the amount of appropriated funding for VA research since FY 2010 has lagged far behind annual biomedical research inflation rates, resulting in a net loss over these years of nearly 10 percent of the program's overall purchasing power. As estimated by the Department of Commerce, Bureau of Economic Analysis, and the National Institutes of Health, for VA research to maintain current service levels, the Medical and Prosthetic Research appropriation should be increased in FY 2018 by 2.7 percent over the FY 2017 baseline simply to keep pace with inflation. With this in mind, *The Independent Budget* recommends approximately $17 million to meet current services demands for research.

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

Emerging Research Needs

In addition to covering uncontrollable inflation, the IBVSOs believe Congress should appropriate an additional $17 million for FY 2018, for expanding research on emerging conditions prevalent among newer veterans, as well as continuing VA's inquiries in chronic conditions of aging veterans from previous wartime periods. For example, additional funding will help VA support areas that remain critically underfunded, including:

- Post-deployment mental health concerns such as PTSD, depression, anxiety, and suicide in the veteran population;

- The gender-specific health care needs of the VA's growing population of women veterans;
- New engineering and technological methods to improve the lives of veterans with prosthetic systems that replace lost limbs or activate paralyzed nerves, muscles, and limbs;
- Studies dedicated to understanding chronic multi-symptom illnesses among Gulf War veterans and the long-term health effects of potentially hazardous substances to which they may have been exposed; and
- Innovative health services strategies, such as telehealth and self-directed care, that lead to accessible, high-quality, cost-effective care for all veterans.

Million Veteran Program

The VA Research program is uniquely positioned to advance genomic medicine through the "Million Veteran Program" (MVP), an effort that seeks to collect genetic samples and general health information from 1 million veterans over the next five years. When completed, the MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of veterans. To date, more than 400,000 veterans have enrolled in MVP. The VA estimates it currently costs around $75 to sequence each veteran's blood sample. Under the President's Precision Medicine Initiative, the IBVSOs recommend $65 million to enable VA to process one quarter of the MVP samples collected.

General Operating Expenses (GOE)

Veterans Benefits Administration

FY 2018 *IB* Recommendation	**$3.135 billion**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$2.856 billion**

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

The *IB* recommends approximately $3.135 billion for the VBA for FY 2018. This amount reflects an increase of approximately $279 million over the enacted FY 2017 appropriations level. Our recommendation includes approximately $183 million in additional funds in the Compensation account above current services, and approximately $32 million more in the VR&E account above current services to provide for new full-time equivalent employees (FTEE).

Compensation Service Personnel **1750 New FTEEs** **$183 million**

VBA continues to produce record numbers of claims while maintaining an emphasis on quality; however, FY 2016 signals a troubling trend. Increases are taking place in total disability claims inventory, backlogged claims, the amount of time it takes to process a claim and appeals workload. These increases can be attributed to multiple factors such as an increase in the number of claims and appeals being filed, the lack of adequate resources to keep pace with demand and the curtailing of mandatory overtime.

Over the past few years, VBA has made significant progress in reducing the disability compensation backlog, which at its peak, stood at over 600,000 claims in March 2013. Today, the claims backlog stands at roughly 96,000 claims, a decrease of nearly 85 percent from its peak, but an increase of roughly 10,000 claims over the previous year. VA defines a backlogged disability claim as one pending over 125 days.

In 2009, VBA issued decisions on 2.74 million medical issues; that number more than doubled to 5.76 million in FY 2016, but was less than FY 2015 when it issued 6.35 million decisions on medical issues. In March of 2013, VBA required roughly 282 days to process a claim. At the close of FY 2016, VBA reported that on average, it took 123 days to process a claim; however, in FY 2015, VBA reported that it took, on average, 92 days to complete a claim.

VBA's total disability claims inventory is also continuing to rise. In FY 2015, their pending claims inventory stood at about 352,000 claims; today, VBA has a total inventory closer to 400,000 claims. This means that one quarter of VBA's total inventory is considered backlogged. Furthermore, VBA has an inventory of nearly 584,000 for non-disability rating claims.

It will take a blend of technology and people to enable VBA to provide veterans and their dependents with more timely and accurate decisions. Necessary personnel increases should not be tempered against hopes of future technological gains. IT systems such as the Veterans Benefits Management System (VBMS), e-Benefits, the Stakeholder Enterprise Portal (SEP) and now, the National Work Queue, though beneficial for enabling VBA keep pace with their overall workload, the full effect of these systems may not be realized for years.

Recognizing that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel, Congress provided VBA with more than 1,300 FTEE between FY 2013 and FY 2017, primarily in Compensation Service. In FY 2016 alone, Congress authorized VBA to hire an additional 770 FTEE. The new FTEE were to be purposed for non-rating activities. However, taking into consideration VBA's total workload, including appeals, these increases in personnel have not been sufficient to keep pace with incoming workload, or to reduce the backlogs in these non-rating areas.

VBA's previous concentrated efforts to reduce the claims backlog caused new backlogs in other activities including appeals. As of February 2017, there were close to 460,000 appeals pending, roughly 360,000 within the jurisdiction of the VBA and the remainder within the jurisdiction of

the Board of Veterans' Appeals. This growing appeals backlog is a result of VBA's former shift in focus and resources to process disability claims, as evidenced by the fact that Decision Review Officers (DRO) and Quality Review Specialists (QRS) were performing development and rating duties during both regular and overtime working hours at many VA regional offices (VARO).

In order for VBA to produce timely and quality decisions, it will require sufficient resources and must modernize its appeals process. Appeals modernization and reform legislation that was introduced in 114th and 115th Congress will help to significantly streamline and simplify appeals processing.

For FY 2018, the IBVSOs recommend an additional 1,750 FTEE. VBA will require this infusion of resources to manage their overall rising workload. Furthermore, as VBA no longer utilizes mandatory overtime for claims processing, true personnel needs must be addressed.

1,000 FTEE would be dedicated to processing appeals at VBA in an effort to eliminate the backlog of 360,000 appeals within the next three years. Depending on the progress made over the next year, further personnel increases may still be necessary to address this appeals backlog.

350 FTEE would be dedicated to address the growing backlog of non-rating related work such as dependency claims. 300 FTEE would be dedicated for claims processing to address the incremental rise in the claims inventory and backlog.

100 FTEE would be dedicated to the Fiduciary program to meet the growing needs of veterans participating in VA's Caregiver Support programs. This recommendation is also based on a July 2015 VA Inspector General report on the Fiduciary program that found, "...Field Examiner staffing did not keep pace with the growth in the beneficiary population, [and] VBA did not staff the hubs according to their staffing plan...."

Finally, as technology and work processes continue to evolve and change the landscape of claims and appeals processing, the IBVSOs believe that more accurate staffing and production models will be required to determine future VBA resource requirements.

VR&E Service Personnel **266 New FTEEs** **$32 million**

The Vocational Rehabilitation and Employment Service (VR&E), also known as the VetSuccess program, provides critical counseling and other adjunct services necessary to enable service disabled veterans to overcome barriers as they prepare for, find, and maintain gainful employment. VetSuccess offers services on five tracks: 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 (VSOC) program deployed 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 (IDES). These additional functions of VR&E personnel are

undoubtedly beneficial to disabled veterans; however, staffing levels throughout VR&E services must be commensurate with current and future demands and their global responsibilities.

Over the past few years, program participation has increased by 15 percent overall, increasing by 7.3 percent in FY 2015, 3.8 percent in FY 2016, and in FY 2017, a 4 percent increase is estimated. In FY 2017, the Administration failed to request adequate staffing levels to keep pace with anticipated demand. In fact, for both FY 2016 and FY 2017, the Administration flat-lined the VR&E request for direct personnel at 1,442.

A steady growth in program participation each year, without commensurate requests for personnel to keep pace with increased program participation will leave service-connected veterans waiting longer for critical services. As VBA continues to expand VR&E eligibility to more veterans, due to increased claims processing and the award of new service-connected disabilities due to new presumptive disabilities, it is not unreasonable to foresee a rise in program participation within VR&E. Based on historical participation rates, the IBVSOs project that total program participation for FY 2018 will grow by at least 5 percent for total caseload of close to 155,000.

Last year, Congress recognized the need for a more balanced client-to-counselor ratio with the enactment of Public Law 114–223, Section. 254. This provision authorizes the Secretary to use appropriated funds to ensure the ratio of veterans to full-time employment equivalents does not exceed 125 veterans to one full-time employment equivalent.

In July 2015, VR&E reported that its average Vocational Rehabilitation Counselor (VRC)-to-client ratio had risen to 1:139. Unless significant new funding is provided, VA would be required to redirect appropriated resources from other vital programs to achieve this ratio within VR&E. Therefore, VR&E's full funding requirements must be included in its budget request and not syphoned away from other programs to reach the 125-to-1 ratio. Even this benchmark may even be too high when taking into consideration the overall responsibilities of VRCs, such as VSOC, IDES and other outreach initiatives.

In order to achieve and sustain a 1:125 counselor–to-client ratio in FY 2018, we estimate that VR&E would need 266 new FTEE, for a total workforce of 1550 FTEE, to manage an active caseload and provide support services to 155,000 VR&E participants. At a minimum, three-quarters, of the new hires should be VRCs dedicated to providing direct services to veterans. This increase in personnel accounts for the expected growth in VR&E claim filings, program participation, collateral duties performed outside of general case management, the flat-lined personnel requests for the previous two fiscal years and our previous 158 FTEE request for last fiscal year.

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 VRC caseloads are equitably balanced among VAROs, which typically experience variable caseloads. As an example, a January 2014 GAO Report found the Cleveland VARO's VRC ratio to be 1:206 and in the Fargo VARO, the ratio was 1:64.

General Administration

FY 2018 *IB* Recommendation **$406 million**
FY 2018 Administration Request
FY 2017 Enacted Final Appropriation **$345 million**

The General Administration account is comprised of ten primary divisions. These include the Office of the Secretary; the Office of the General Counsel; the Office of Management; the Office of Human Resources and Administration; the Office of Enterprise Integration; the Office of Operations, Security and Preparedness; the Office of Public Affairs; the Office of Congressional and Legislative Affairs; and the Office of Acquisition, Logistics, and Construction; and the Veterans Experience Office (VEO). This marks the first year that the VEO has been included in the divisions of General Administration. Additionally, a number of the divisions reflect changes to the structure and responsibilities of those divisions. For FY 2018, the *IB* recommends approximately $406 million, an increase of more than $60 million over the FY 2017 appropriated level. This increase primarily reflects an increase in current services based on the impact of uncontrollable inflation across all of the General Administration accounts. It also reflects the establishment of the VEO within the General Administration accounts.

Board of Veterans' Appeals

FY 2018 *IB* Recommendation **$158 million**
FY 2018 Administration Request
FY 2017 Enacted Final Appropriation **$156 million**

Faced with a growing number of claims and resultant appeals that could no longer be ignored, Congress authorized the Board of Veterans' Appeals (Board) to increase their FTEE by 242 over FY 2016 authorized levels, bringing their total authorized staffing to 922 FTEE for FY 2017. For FY 2018, the IBVSOs recommend no additional increases in FTEE; however, the Board must be permitted to hire their full complement of 922 FTEE. Today, the Board's total FTEE strength is close to 855 FTEE. Over the past few years, the Board has averaged approximately 85 appeal dispositions per FTEE, producing 55,532 decisions in FY 2014, 55,713 decisions in FY 2015 and are expected to issue somewhere close to 56,000 decisions in FY 2016. If the Board were to reach their full complement of 922 FTEE, at 85 appeal dispositions per FTEE, they could be expected to issue close to 78,000 decisions.

As the number of claims processed annually continues to rise as a result of the increased capacity of VBA, the number of appeals is also expected to continue rising. Even with increased accuracy in rating board decisions, on average 10 to 12 percent of claims decisions are appealed. Thus, assuming VBA processes 1.5 million claims in 2018—a reasonable estimate considering VBA processed over 1.4 million claims in both FY 2014 and FY 2015–roughly 150,000 appeals would enter the system, with roughly half of them continuing on to the Board for appellate review. In

order for the Board to keep pace with only this new incoming workload and not those appeals already in the system, their FTEE levels would have to be adjusted accordingly, unless comprehensive reforms are adopted.
In the 114th Congress, significant appeals-reform legislation was introduced. The legislative language reflected significant efforts of a working group formed in March 2016 that consisted of the IBVSOs, other VSO stakeholders, and leaders within VBA and the Board. This legislation would have fundamentally reformed and streamlined the overall appeals process
Similar legislation has been introduced in the 115th Congress. Without these reforms, traditional staffing increases will be required to meet current and future workload requirements. As it stands today, to keep pace with their overall workload, the Board will need to continue adding new attorneys, veteran law judges, as well as sufficient support staff.

Additional staffing is just one component that is needed to effectively manage the appeals workload. Seamless and functional IT systems are also critical to ensure the Board is able to issue accurate and timely decisions. There must be integration with the Veterans Benefit Management System, but also the flexibility for their Board to perform work functions centric and independent to the appeal process.

Over the past few years, the Board has received resources and developed partnerships to modernize its IT systems, which is essential to improving quality and timeliness of appeal decisions. Part of this modernization involves replacement of the outdated legacy appeals tracking system, (VACOLS). In order to accomplish this modernization, the Board partnered with The United States Digital Service (USDS). The USDS is a White House tech initiative that works across the Federal government to enhance and improve IT services.

The USDS team has been working on multiple integration tools, one of which was Caseflow Certification that became operable in April 2016. Caseflow Certification is an IT enhancement that automatically detects if certain documents have been secured before moving forward in the appeal process. The partnership between the USDS team must be allowed to reach its full maturity, so the Board can reap the rewards of their innovations that are designed to improve the appeals process for waiting appellants.

Lastly, the USDS must be allowed to continue to operate in the non-traditional, agile way it has pioneered at VA so that it can continue to pursue the best-possible approach to modernization instead of being locked down into an inflexible multi-year development plan that that cannot possibly anticipate the lessons that will be learned during development.

Departmental Administration and Miscellaneous Programs

Information Technology

FY 2018 *IB* Recommendation	**$4.362 billion**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$4.278 billion**

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

For FY 2018, the IBVSOs recommend approximately $4.4 billion for the administration of the VA's IT program. This recommendation includes no new funding above the planned current services level. Significant resources have already been invested in VA's IT programs in recent years, and we believe proper allocation of existing resources can allow VA to fulfill its missions while modernizing its systems. We continue to call for acceleration of the VBMS, and the implementation of an appropriate solution for the Board of Veterans Appeals IT system.

Additionally, it is critical to ensure that sufficient funds are directed at the incremental costs of implementation for the new Veterans Choice Program (VCP). The VA identified a series of one time incremental costs for IT systems in order to redesign, develop, and deliver systems and technology solutions for the new VCP. Those incremental costs range from $421 million in Phase I of the project, to $606 million in Phase II, and finally $851 million in Phase III. Without having a clear plan for when each of these Phases might actually take place, The Independent Budget has chosen not to explicitly recommend these funds in our IT funding recommendation. However, we believe Congress must consider these costs in an effort to assist the VA in implementing the new VCP.

National Cemetery Administration

FY 2018 *IB* Recommendation	**$291 million**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$286 million**

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

In a strategic effort to 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 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 Native American, Alaska Native, and Pacific Islander 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 $291 million for FY 2018 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 each year. 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 2018 *IB* Recommendation	**$163 million**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$160 million**

The Office of Inspector General (OIG) received a significant infusion of new resources for FY 2016 due to the high volume of work that it has produced. And yet, the OIG has been under significant scrutiny over the past two years. 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. We believe that the substantial increase that the OIG received in FY 2016 should allow it to expand its staffing sufficiently to meet the ever-growing demands on its work. With this in mind, the *IB* recommends funding based on current services for FY 2018 of approximately $163 million.

Construction Programs

Major Construction

FY 2018 *IB* Recommendation	**$1.50 billion**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$528 million**

Currently, VA has 24 major construction projects that are partially funded, some of which were originally funded in FY 2004, that need to be put on a clear path to completion. There are an additional 3 projects that are in the design phase. Outside of the partially funded major projects list are major construction projects at the top of the FY 2017 priority list that are seismic in nature. These projects cannot take a strategic pause while Congress and VA decide how to manage capital infrastructure long-term.

Of those 24 partially funded projects, VA will need to invest more than $3.5 billion to complete them all. Of the top five projects on the priority list, two of them are seismic deficiencies, two are the core mission of VA – a mental health clinic and a spinal cord injury center – and one that is an addition to an existing facility. The total cost of these projects is $1.2 billion.

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

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, system wide 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-2016, 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 2017 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 2018 *IB* Recommendation	**$700 million**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$372 million**

In FY 2017, Congress appropriated $372.1million for minor construction projects. Currently, there are still approximately 600 minor construction projects that need funding to close all current and future year gaps within 10 years. To complete all of these current and projected projects, VA will need to invest between $6.7 and $8.2 billion in minor construction over the next decade.

In August 2014, the President signed the Veterans Access, Choice, and Accountability Act of 2014 (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 that obligated $511 million for 64 minor construction projects over a two-year period.

While this infusion of funds has helped, there are still hundreds of minor construction projects that need funding for completion. It is important to remember that these funds are a supplement to, not a replacement of, annual appropriations for minor construction projects. The IBVSOs recommend that Congress fund VA's minor construction account at $700 million in an effort to close all identified gaps within 10 years.

Leasing: Historically VA has submitted capital leasing requests that meet the growing and changing needs of veterans. VA has again requested an adequate amount, $283.7 million for its FY 2017 leasing needs. While VA has requested adequate resources, Congress must find a way to authorize and appropriate leasing projects in a way that precludes the full cost of the lease being accounted for in the first year. There are currently 18 major medical leases from FY 2016 and six from FY2017 that Congress must still authorize. Delays in authorization of these leases

has a direct impact on VA's ability to provide time care to veterans in their communities. Congress must authorize these leases.

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

FY 2018 IB Recommendation	**$300 million**
FY 2018 Administration Request	
FY 2017 Enacted Final Appropriation	**$90 million**
FY 2017 IB Recommendation	**$200 million**

Grants for state extend-care facilities, commonly known as state home construction grants, are a critical element of federal support for the state veterans' homes. The state home program is a very successful federal-state partnership in which VA and states share the cost of constructing and operating nursing homes and domiciliaries for America's veterans. State homes provide over 30,000 nursing home and domiciliary beds for veterans, their spouses, and gold-star parents of deceased veterans. Overall, state homes provide more than half of VA's long-term-care workload, but receive less than 15 percent of VA's long-term-care budget. VA's basic per diem payment for skilled nursing care in state homes is significantly less than comparable costs for operating VA's own long-term-care facilities. This basic per diem paid to state homes covers approximately 30 percent of the cost of care, with states responsible for the balance, utilizing both state funding and other sources. 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.

States construction grants help build, renovate, repair, and expand both nursing homes and domiciliaries, with states required to provide 35 percent of the cost for these projects in matching funding. VA maintains a prioritized list of construction projects proposed by state homes based on specific criteria, with life and safety threats in the highest priority group. Only those projects that already have state matching funds are included in VA's Priority List Group 1 projects, which are eligible for funding. Those that have not yet received assurances of state matching funding are put on the list among Priority Groups 2 through 8.

In FY 2017, the estimated federal share for the 99 state home construction grants requests that have been submitted by states was almost $1.1 billion. Of that amount, the states had already secured their share of matching funds required to put them in the Priority Group List 1 for 57 projects that will require $639 million in federal matching funds, an increase of $89 million over FY 2016. Last year, VA requested only $85 million and the IBVSOs had recommended $200 million; Congress ultimately appropriated $90 million funding for FY 2016, which will barely keeps up with the increase in Priority Group 1 projects. With almost $1 billion in state home projects still in the pipeline, the IBVSOs recommend $300 million for the state home construction grant program for FY 2017 in order to begin seriously addressing the remaining $550 million backlog of Priority 1 projects, as well as the $433 million of Priority 2-8 projects soon to receive matching funding from the States.

Grants for State Veterans Cemeteries

FY 2018 *IB* Recommendation	**$46 million**
FY 2018 Administration Request	
FY 2017 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 2018 will provide burial options for an additional 148,000 veterans. To fund these projects, Congress must appropriate $46 million.

Mr. DENT. Without objection, we will receive that.

Mr. BLAKE. Thank you.

You can also find this report at www.independentbudget.org, and it can be downloaded there, as well.

Let me begin by saying that while we appreciate the administration has stated that it intends to recommend an increase in the Department of Veterans Affairs budget for 2018—less clarity about fiscal year 2019 as it relates to advance appropriations—the fact is that the devil will be in the details. There are still many questions that remain about how the Administration will fund the priorities for the VA when the more detailed budget comes out later this spring.

The fiscal year 2018 projections are of particular concern for us with the Independent Budget. The previous secretary of VA, Robert McDonald, actually testified last year that they knew that their fiscal year 2018 advance appropriations recommendations were not going to be sufficient to meet what they projected to be demand; yet, Congress acted upon that recommendation last year in the appropriations bill.

It will be critically important for this subcommittee, for the full committee, for the House and the Senate to address what we know is a shortfall that the VA itself identified in continued funding for fiscal year 2018 that will come into play beginning in October of this year.

We also believe it is necessary to consider the projected expenditures as it relates to the Choice program. Obviously the Choice program is a hot topic on the Hill, in the VA, and the VSO community.

Last year in the VA's budget they projected as much as $5.7 billion in remaining funds for Choice. That was a year ago.

That number was revised to about $2.9 billion later through the course of the year. Currently the VA is projected to have as much as $1 billion remaining when the Choice program is set to expire in August.

We support the legislation that has been moved by the House that will relieve the VA of its authority based on the date of expiration for the Choice program, but I would say that we don't believe that the Choice program, as currently constructed, is the optimal way forward. I don't think anybody actually disagrees with that notion. I think it obviously needs some changes, some improvements, or maybe something that is just better.

But there are still a lot of questions remaining about how the Choice—or how that concept will look going forward and the funding associated with it.

The current Choice program is covered under emergency designation as mandatory spending. What will that look like beginning after August or beginning in the next fiscal year? That is a serious question for us, a serious concern. Certainly it is a serious issue that you all will have to grapple with.

As outlined in our budget, the I.B. recommends approximately $77 billion in total medical care funding for fiscal year 2018. Congress previously appropriated about $70 billion; that takes into account collections, as well.

I think the important thing to understand about how the Independent Budget makes its recommendations is we provide an over-

all snapshot of exactly what it costs to provide care from the VA, and that is a combination of things, from providing care as an inpatient or in the system of care of the VA, whether it be in the community, whether it be through Choice.

Our view is the total view of what it actually requires to provide services to VA—or to veterans secondary to VA. That is outlined in greater detail in our budget report.

There are a couple of issues I would like to highlight quickly that are included in our recommendations.

One is continued funding and increased funding for women veterans programs. Obviously this has become a growing issue.

This is a fast-growing population that VA is serving. We recommend about $110 million additional dollars in 2018, $120 million in fiscal year 2019, and that is explained in detail.

Another hot topic is reproductive services, assisted reproductive technology, that was included in the appropriations bill, which we thank you all for, last year. It carries us, as we understand it, through the end of fiscal year 2018. It is critical that that program gets carried forward.

And then lastly, the Staab ruling involving emergency care services. Everyone believes that the VA has interpreted the ruling—misinterpreted the legislation that was passed all the way back in 2009 about its obligation for meeting emergency care costs for veterans, and they now are on the hook for what may be as much as $10 billion over the long haul because of their decision to not pay for those services, as they are required by law.

Lastly, we include a recommendation for medical and prosthetic research to the tune of about $713 million, along with additional money targeted at the Precision Medicine Initiative that the VA has designated. That would bring the total for research up to about $778 million. It cannot be overstated enough the importance of research as a part of the mission of VA.

With that, Mr. Chairman, I thank you for the opportunity to testify. Be happy to answer any questions that you or the members of the subcommittee may have.

[The information follows:]

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Carl Blake is the Associate Executive Director of Government Relations for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's National Legislative and Advocacy Program agendas with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues, as well as disability civil rights. He also represents PVA to federal agencies including the Department of Veterans Affairs, Department of Defense, Department of Labor, Small Business Administration, the Department of Transportation, Department of Justice, and the Office of Personnel Management. He coordinates all activities with PVA's Association of Chapter Government Relations Directors as well with PVA's Executive Committee, Board of Directors, and senior leadership.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 2nd Battalion, 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute training exercise.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.

STATEMENT OF CARL BLAKE

ASSOCIATE EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS

PARALYZED VETERANS OF AMERICA

ON BEHALF OF THE CO-AUTHORS OF THE INDEPENDENT BUDGET

BEFORE THE HOUSE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON MILITARY CONSTRUCTION AND VETERANS' AFFAIRS

CONCERNING

***THE INDEPENDENT BUDGET* AND THE DEPARTMENT OF VETERANS AFFAIRS**

BUDGET FOR FISCAL YEAR 2018 AND FISCAL YEAR 2019

MARCH 29, 2017

Chairman Dent, Ranking Member Wasserman Schultz, and members of the Subcommittee, as one of the co-authors of *The Independent Budget* (IB), along with DAV and Veterans of Foreign Wars, Paralyzed Veterans of America (PVA) is pleased to present our views regarding the funding requirements for the delivery of health care for the Department of Veterans Affairs (VA) for FY 2018 and advance appropriations for FY 2019. While we appreciate that the Administration plans to request an increase in funding for the VA, the fact is the "devil will be in the details."

The IB's recommendations include funding for all discretionary programs for FY 2018 as well as advance appropriations recommendations for medical care accounts for FY 2019. The full budget report recently released by *The Independent Budget* addressing all aspects of discretionary funding for the VA can be downloaded at www.independentbudget.org. The FY 2018 projections are particularly important because previous VA Secretary Robert McDonald admitted last year that the VA's FY 2018 advance appropriation request was not truly sufficient and would need significant additional resources provided this year. We hope that Congress will take this defined shortfall very seriously and appropriately address this need. Our own FY 2018 estimates affirm this need.

We also believe it is necessary to consider the projected expenditures under the Choice program authority that the previous Administration planned in FY 2017 and how that impacts the baseline that will dictate the funding needs for FY 2018. The previous Administration assumed as much as $5.7 billion in spending through the Choice program in FY 2017, on top of the Medical Services discretionary funding and the newly created Medical Community Care account. That amount was revised to approximately $2.9 billion. This means that the VA projected to spend more than $59.0 billion in Medical Services and more than $71.0 billion in overall Medical Care funding in FY 2017. Currently, the VA projects having nearly $1 billion remaining beyond the mandated Choice expiration date in August of this year. We fully support legislation (passed by the House) that would allow the VA to spend the remaining Choice funds—approximately $1 billion—after the expiration date in August of this year. These considerations inform the decisions of *The Independent Budget* to establish our baseline for our funding recommendations for both FY 2018 and FY 2019. Additionally, we believe going forward that services delivered through the Choice program should be integrated with the VA's Community Care account for funding purposes to eliminate competing sources of funding for delivery of health care services in the community, while maintaining visibility on spending through the Choice program.

For FY 2018, the *IB* recommends approximately $77.0 billion in total medical care funding. Congress previously approved only $70.0 billion for this account for FY 2018 (which includes an assumption of approximately $3.6 billion in medical care collections). The IB's recommendation also considers the approximately $1 billion VA is expected to have remaining in the Veterans Choice Fund and expected demand for care, including community care, that will not diminish or go away if the Choice Program expires. *The Independent Budget* recommends approximately $82.8 billion in advance appropriations for total Medical Care for FY 2019.

Medical Services

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

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

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate also assumes a 1.5 percent increase for pay and benefits across the board for all VA employees in FY 2018. It was recently reported that the new Administration would like to consider a 1.9 percent federal pay raise. Additionally, *The Independent Budget* believes that there are medical program funding needs for VA that must be considered. Those costs total approximately $2.0 billion.

Long-Term Services and Supports

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

Prosthetics and Sensory Aids

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

Women Veterans

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

Reproductive Services (to Include IVF)

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

Emergency Care

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

FY 2019 Medical Services Advance Appropriations

The Independent Budget once again offers baseline projections for advance appropriations for the Medical Care accounts for FY 2019. As indicated previously, we have serious concerns that the previous Administration significantly underestimated its FY 2018 advance appropriations request. This trend cannot be allowed to continue.

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

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

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

Medical Support and Compliance

For Medical Support and Compliance, *The Independent Budget* recommends $6.7 billion for FY 2018. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2017 appropriated level. Additionally, for FY 2019 *The Independent Budget* recommends $6.8 billion for Medical Support and Compliance.

Medical Facilities

For Medical Facilities, *The Independent Budget* recommends $5.8 billion for FY 2018. Our Medical Facilities recommendation includes $1.35 billion for Non-Recurring Maintenance (NRM). Likewise, *The Independent Budget* recommends approximately $6.6 billion for Medical Facilities for FY 2019. Our FY 2019 advance appropriation recommendation also includes $1.35 billion for NRM.

Medical and Prosthetic Research

The VA Medical and Prosthetic Research program is widely acknowledged as a success on many levels, and contributes directly to improved care for veterans and an elevated standard of care for all Americans. We recommend that Congress appropriate $713 million for Medical and Prosthetic Research for FY 2018. Additionally, under the President's Precision Medicine Initiative, the IBVSOs recommend $65 million to enable VA to process one quarter of the MVP samples collected, for a total research appropriation of $778 million.

Thank you for the opportunity to testify. We would be happy to answer any questions you have.

Mr. DENT. Thank you very much for your testimony, Mr. Blake. We really appreciate it.

We haven't seen a detailed budget yet for the VA, obviously, but we know from what the administration has provided in the skinny budget that your fiscal year 2018 Independent Budget comes in at more than $9 billion above the President's request. Since the budget treats VA far better than any other domestic discretionary program or agency, I don't know how our subcommittee would be able to provide that kind of funding increase.

PROGRAMS WITH THE MOST URGENT NEED FOR INCREASED FUNDING

So I only have really one question: Realizing that we won't be able to handle your total request, which areas can you identify within the VA that have the most urgent need for increased funding?

Mr. BLAKE. Well, I think there is no question but the medical care section, particularly under medical services, is the most critically important.

To understand how the I.B. frames its recommendation, our medical services recommendation, if you were to line it up with what the VA recommends for its dollars, the VA's comparable recommendation would look like their medical services, plus their medical and community care account, plus their Choice program funding that they have planned.

So that is how you align what we recommend. We don't break those out because truthfully, from our perspective it is a complicated proposition to figure out what community care spending might actually be.

So medical care in particular is by and large the most important.

I think where you see one of the big deviations in our recommendations from the administration is in the construction area. That has been the case for many, many years now. One of our long-running frustrations is particularly in the area of major construction, to a lesser degree minor construction.

The VA has billions of dollars in projects that are setting in the queue, and my colleague from the VFW will talk about that so I won't steal his thunder in that respect. But that is a serious concern that we have because there hasn't been enough commitment.

From the I.B.'s perspective we have considered in our policy agenda, you know, innovative ways to address the construction issue, recognizing that that part of VA is under scrutiny in places like Denver, New Orleans, Orlando—places where we are not satisfied with how that was handled; I know you all are not satisfied how—with how those things were handled.

So construction remains a serious issue.

I think in light of the VA's announcement about its plans for information technology, a star needs to be put next to that because it is going to be hard to rationalize the cost in I.T. with what the new secretary has stated as his desired goal, to move towards a commercial off-the-shelf, and how that might impact the funding.

I.T. has increased year over year for a number of years now, but we don't know what impact that this decision might have on that decision by the VA moving forward.

So I think I.T. is critical, as well.

We try to take a view that a number of the administrative accounts are—we take a conservative approach to a lot of the administrative accounts. You see that in our recommendations for medical support and compliance, general administration, some of the areas where we believe there is probably too much bloat in the VA and that—we don't necessarily ascribe to the belief that those should just increase for the sake of increasing.

So I think if you look at our recommendations you will see that we try to treat those fairly without going out of the bounds of what seems reasonable.

So short answer to your question, medical services for sure, the construction areas for sure, I.T. for certain.

I also will just sort of touch on the issue that my other colleague from the DAV will mention: funding for the Veterans Benefits Administration. The number of claims is not going down.

We still also have to grapple with the issue of appeals modernization, the cost associated with that. And I think the subcommittee is going to have to figure out how to rationalize what the authorizers are trying to do, along with the VSO community and the VA, in appeals modernization and how that impacts the larger claims process, as well.

Mr. DENT. Ms. Wasserman Schultz.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

ASSISTED REPRODUCTIVE TECHNOLOGY

First, thank you for your service and your testimony.

On the assisted reproductive technology language, I was proud to join my colleague, Congresswoman Brownley, in making sure that that language was there, and we followed up with a letter to the VA to make sure that there was a clear understanding that the idea is that this is not just a 1-year policy and that we expect that they would permanently make sure that we can provide this assistance and coverage. So as someone whose—two of three children were conceived through in vitro fertilization, so I certainly know what it is like to struggle with the challenge of infertility no matter what its cost.

PARKING AT VA FACILITIES

I do want to ask you on—about the challenges that your members might have with parking at VA facilities, because I, you know, represent the Miami area, and I—when I went to the University of Florida, I have never seen a parking problem like they have at the Miami VA—and that is saying something.

So come to find out that it is actually against the law to shuttle employees of the VA, as opposed to shuttling veterans. So when a medical center comes up with a solution to park employees in an offsite lot and shuttle them, versus parking veterans at an offsite lot and shuttle them, or have veterans park at the further part of the—end of the parking lot and shuttle them versus employees, that seems to me to be somewhat backwards.

So I am going to be filing legislation—likely along with Chairman Roe and hopefully Chairman Dent—and we are working with the secretary—to correct that. But I wanted to see—I would imag-

ine that it is a unique and particular problem for the paralyzed veterans, so——

Mr. BLAKE. Well, ma'am, I would say, being a regular user of the VA—and I go to the Richmond VA. I have been using that VA for 17 years now, and all I have seen is the parking lot grow to the point that they have knocked down towns around it to build out more parking lot. If you don't go there—if you have a 9 o'clock appointment and you are not there at 6:30 or 7 o'clock you are not parking in the parking lot.

I can make the argument that that is a reflection of the demand being placed on the system. Parking is sort of a microcosm of the larger demand for health care services.

And that is the demand on a facility like Richmond. Many of the major VA hospitals are like that.

I was not aware of the legal challenge you referenced there, but it seems kind of silly. I am sure there are some liability issues that make it more complicated than I would like to believe, but——

Ms. WASSERMAN SCHULTZ. Well, the secretary——

Mr. BLAKE [continuing]. But there is no question but that parking is a serious problem. I mean, many of the facilities have brought in valet as an option. All that has done is squeeze, you know, drive-up-and-park parking. I mean, it is certainly a major issue.

Ms. WASSERMAN SCHULTZ. It is hard to imagine what member of Congress thought it would be a good idea to prohibit employees from being shuttled, but hopefully we are going to be able to correct that.

PARALYZED VETERANS HAVING ACCESS TO CHOICE PROGRAM

And then the other question I had was how are paralyzed veterans experiencing access inside and outside the VA to the Choice program?

Mr. BLAKE. I would say that primarily our members don't use Choice because there is not a whole lot of comparable systems to the VA's SCI system of care outside of VA. You do have 14 model systems of care around the country. The majority of those don't even meet CARF certification, which is one of the—sort of the overarching rehab certifications used for many of the VA SCI systems of care.

We encourage our members to use VA's spinal cord injury system, particularly for annual physicals and preventive care. There are barriers and challenges to that.

But by and large our members have not taken advantage of the Choice option. I do know that, much like many of the other veterans that have taken advantage, they have struggled when they have taken advantage of the opportunity.

I think one of the common problems our members have seen is when taking advantage of the opportunity to use Choice, they find that waits are just as long in the community to receive care or that the service that they are trying to avail themselves of is not necessarily available in the community in which they live.

So I think that in the event of our members using Choice, their experiences are not uniquely different necessarily than what the larger population that is taking advantage of it have experienced.

Ms. WASSERMAN SCHULTZ. Thank you.
Yield back.
Mr. DENT. Mr. Taylor.
Mr. TAYLOR. Thank you, Mr. Chairman.
Thank you for—appreciate your service, appreciate that you are in Virginia, and——

EMERGENCY CARE COURT DECISION

Mr. BLAKE. Yes, sir. Thank you.
Mr. TAYLOR [continuing]. And certainly appreciate your advocacy. So thank you very much.
Just really quick, emergency care in the VA paying by law: Can you just expound upon that for people like me who are new here and haven't seen that?
Mr. BLAKE. So in 2009 legislation was enacted—and I am not the subject matter expert, so I will freely admit that—legislation was enacted that basically obligated VA to provide—to pay for your care when you have to get emergency care in the community.
The VA, as I understand it, has interpreted that legislation so that they don't—they have not. This gentleman, Staab, sued the VA because he had an experience where he had had to take advantage of emergency care in the community and his bills were not paid. And the court at the federal level ruled in his favor.
The VA is currently appealing a ruling that everyone knows they are going to lose. At every level that has already been determined.
I think the secretary maybe understands this, but they continue to resist what is the inevitable. And because of their resistance, the bill is just continuing to build.
And so the $10 billion cost is over I think a 10-year period, but the current-year cost for the reimbursement is like $1 billion. And it is sort of a trickle-up effect, but it stays in that realm.
Bottom line is the VA is on the hook to pay for these emergency bills for well over $1 billion each fiscal year now, and they are not paying any of that.
Mr. TAYLOR. Thank you.
Thank you, Mr. Chair.
Mr. DENT. Thank you, Mr. Taylor.
At this time I recognize Mr. Bishop.
Mr. BISHOP. Thank you very much.
And welcome, Mr. Blake.

CONSOLIDATING COMMUNITY CARE PROGRAMS

As you are aware, in 2015 the VA delivered a plan to Congress outlining steps to consolidate community care programs. The plan would consolidate and streamline existing community care programs into an integrated care delivery system and enhance the way that VA partners with other federal health care providers, academic affiliates, and community providers.
But the Choice and Community Care programs are currently funded from different accounts. There seems to be some problems with their being funded from two accounts—for example, with the Choice being funded from a subsidy-managed account at VA and Community Care being funded at the medical center level. That can present inconsistency of the implementation there, depending

on what the local budget is at the community level, at the medical center level.

Can you speak to that? Do you think that the provisions of Choice and Community Care programs should be funded from the same account, or you think that that would provide better services to our veterans?

Mr. BLAKE. Well, Mr. Bishop, the I.B. organizations generally supported what the VA had laid out as a plan back in 2015 for its consolidation. We believe that that is a reflection of the right way forward.

Continuing to have clearly defined, separate programs, from Community Care over here in VA and Choice, is not the way forward. I think VA recognizes that.

When the VA presented its plan in 2015 to the authorizers almost universally the committee supported it. Yet, we seem to have reached a point of collective amnesia that they might have actually supported that. But I think that is the right way forward, and I think the VA has been working towards that end for the last year-and-a-half.

There are a number of legislative authorities that are still hanging in the balance that are required to effect those changes.

At the end of the day, the I.B. has supported a singular Community Care program. Our policy agenda, which we released back at the end of January and can also be found on our Web site at www.independentbudget.org, explains our view of how that whole integration process should work, our own recommendations to affect the implementation of that, and how it should work.

But I think it is not a good idea to continue forward indefinitely with Choice over here and Community Care over here. If nothing else, you run into the problem we had early last year, where the VA took advantage of its Community Care and over-obligated itself, and then they were forced to come to the Hill and say, "Hey, we need to borrow money from ourselves, which is in the mandatory account of Choice over here, just to be able to pay the bills that we had obligated for care in the community."

So I think that that creates an obvious problem for the VA in managing its total Community Care——

Mr. BISHOP. Thank you very much.

Mr. DENT. Thank you, Mr. Bishop.

Mr. Blake, thank you so much for your testimony. We sincerely appreciate it, and we are going to take the rest of your remarks under advisement. So thank you, and——

Mr. BLAKE. Yes, sir.

Mr. DENT [continuing]. We appreciate your testimony before us today.

Mr. BLAKE. Thank you very much.

Mr. DENT. At this time I would like to recognize Mr. Varela—Paul Varela. Paul is the assistant national legislative director at the DAV, Disabled American Veterans.

So, Mr. Varela, we are pleased to have you, and when you are settled and ready we will recognize you for 5 minutes. Again, thank you for joining us.

Mr. VARELA. Thank you, Mr. Chairman.

Mr. DENT. You are recognized for 5 minutes.

WEDNESDAY, MARCH 29, 2017.

DISABLED AMERICAN VETERANS

WITNESS

PAUL VARELA, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR

Mr. VARELA. Chairman Dent, Ranking Member Wasserman Schultz, and members of the subcommittee, good morning. Thank you for providing DAV and our Independent Budget partners with an opportunity to discuss our recommendations for fiscal year 2018 funding requirements essential to the Department of Veterans Affairs' ability to efficiently process and deliver benefits to veterans, their families, and survivors.

As one of the co-authors of the Independent Budget, I will focus my comments on resource requirements for programs within the Veterans Benefits Administration—VBA, and the Board of Veterans Appeals.

Compensation services is responsible for processing claims related to disabilities and other non-disability-related claims, such as those based on changes in dependency status and award adjustments based on veterans returning to active duty. Additionally, VBA is responsible for processing local-level appeals.

For fiscal year 2018 the Independent Budget recommends increasing staff by 750 new FTEE. This staffing increase is needed to address the rising disability rating claims backlog, the appeals backlog, and backlog of non-rating-related claims.

Today VBA is responsible for roughly 380,000 appeals at various stages in the appeals process. Of the 750 new FTEE request, we recommend that 1,000 FTEE be dedicated to driving down the appeals inventory. With this infusion of much-need manpower we estimate the appeals inventory could be reduced to a manageable level within the next 3 years.

Next, vocational rehabilitation and employment services, VRE, 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. For fiscal year 2018 the Independent Budget recommends increasing staff by 266 new FTEE.

Over the past few years VRE program participation has increased steadily without commensurate staffing increases. Furthermore, as VBA continues to expand VRE eligibility to more service-connected veterans due to increased claims processing and changes in law, we project that total program participation for fiscal year 2018 will grow by at least 5 percent, for a total caseload of close to 155,000 participants. Therefore, commensurate staffing levels are critical to ensure VRE services are delivered in a timely and efficient manner to facilitate successful program participation.

Finally, the Board of Veterans Appeals must be permitted to onboard the full complement of FTE that was authorized for fiscal year 2017. Congress authorized the Board of Veterans Appeals a

total of 922 FTE for fiscal year 2017. To date, they have only been able to increase their FTE by roughly 880.

The issue of timely and efficient appeals processing has received considerable attention and been the subject of much debate—rightfully so. On average, it can take close to 5 years to get a resolution on an appeal that is being considered by the Board of Veterans Appeals.

As I am sure we can all agree, subjecting veterans to a 5-year wait period in any capacity is simply unacceptable, and they are counting on us to correct this inequity.

However, there is some good news. Congress, VA, the Independent Budget partners, and other stakeholders have been working diligently to reform the appeals process to make it less complicated and more efficient overall. This reform has often been referred to as "the new framework."

Legislation has been introduced in both the House and Senate, and we are hopeful it will be enacted into law this year. We believe this will provide veterans with more timely and accurate decisions while protecting their rights.

However, regardless if appeals reform legislation becomes law, an essential component going forward will be adequate resources for the Board of Veterans Appeals to process not just appeals within the new framework, but processing equitability for appeals within the current inventory in a timely and efficient manner.

We must ensure that appeals languishing within the current system are not treated as a lesser priority in favor of a more expeditious appeals processing within a new system. Each and every veteran within the appeals process must be treated fairly and equally.

Chairman Dent, Ranking Member Wasserman Schultz, and members of the subcommittee, thank you again for this opportunity to present the Independent Budget's resource recommendations for fiscal year 2018, and I look forward to your questions.

[The information follows:]

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Biographical

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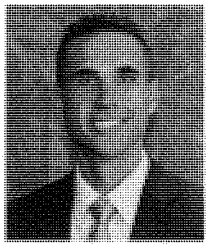

Paul Varela, a disabled U.S. Navy veteran, was appointed Assistant National Legislative Director for the 1.3 million-member DAV on July 1, 2013. He is employed at National Service & Legislative Headquarters in Washington, D.C.

As a member of the DAV's legislative team, Varela works to support and advance federal legislative goals and policies of DAV to assist disabled veterans and their families, and to guard their current benefits and services.

Varela enlisted in October 1998, serving until honorably discharged due to service-connected disabilities in 2001. His military awards and decorations include the Navy & Marine Corps Achievement Medal, Coast Guard Meritorious Unit Commendation, Humanitarian Service Ribbon and Sea Service Deployment Ribbon.

Prior to his appointment as Assistant National Legislative Director, Varela was the Supervisor of DAV's National Service Office in Los Angeles from 2008 until 2013. There, he served as assistant supervisor from 2006 to 2008, and Associate National Service Officer from October 2002 until 2005.

Varela was elected by his peers to serve as President of DAV's National Guild of Attorneys in Fact from 2009 through 2011. He has held a variety of leadership positions within the Guild.

Varela was a member of DAV's National Service & Advisory Committee (2007-2011) and served on several assignments at the Board of Veterans' Appeals in an appellate review capacity. He became a member of the Case Management System Technical Enhancement Committee in 2006.

Varela has been active in the fraternal ranks for many years, serving in nearly every possible leadership capacity at the chapter level.

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STATEMENT OF PAUL VARELA

DAV ASSISTANT NATIONAL LEGISLATIVE DIRECTOR

ON THE FY 2018 APPROPRIATIONS BILL

HOUSE MILITARY CONSTRUCTION, VETERANS AFFAIRS AND RELATED AGENCIES APPROPRIATIONS SUBCOMMITTEE

MARCH 29, 2017

Chairman Dent, Ranking Member Wasserman Schultz, and members of the Subcommittee, as one of the co-authors of *The Independent Budget* (IB), along with Veterans of Foreign Wars (VFW) and Paralyzed Veterans of America (PVA), DAV is pleased to present our views regarding fiscal year (FY) 2018 funding requirements to support the Department of Veterans Affairs (VA) ability to process and deliver benefits to veterans, their families and survivors.

GENERAL OPERATING EXPENSES (GOE)

Veterans Benefits Administration **$3.135 billion**

The Veterans Benefits Administration (VBA) account is comprised of six primary divisions. These include Compensation; Pension; Education; Vocational Rehabilitation and Employment (VR&E); Housing; and Insurance. The increases recommended for these accounts primarily reflect current services estimates with the impact of inflation primarily accounting for the increase. However, the IB recommendations for Compensation and VR&E also reflect a significant increase in requested staffing to meet the rising demand for those benefits. The *IB* recommends approximately $3.135 billion overall for VBA for FY 2018, an increase of approximately $279 million over the enacted FY 2017 appropriations level. The IB

recommendation includes an increase of $183 million above current services in the Compensation account, and approximately $32 million above current services in the VR&E account to provide for new full-time equivalent employees (FTEE) to address rising workload.

Compensation Service Personnel **1750 New FTEEs** **$183 million**

VBA continues to produce record numbers of claims while maintaining an emphasis on quality. Over the past few years, VBA has made significant progress in reducing the disability compensation backlog, which at its peak, stood at over 600,000 claims in March 2013. Today, the claims backlog stands at just over 100,000 claims, a decrease of more than 85 percent from its peak, but an increase of about 15,000 claims over the previous year. There has also been a troubling rise in the overall disability claims inventory and the amount of time it takes to process both claims and appeals. These increases can be attributed to multiple factors, including an increase in the number of claims and appeals being filed, the lack of adequate resources to keep pace with demand and the curtailing of mandatory overtime to reduce the claims backlog.

In 2009, VBA issued claims decisions on 2.74 million medical issues; that number more than doubled to 5.76 million in FY 2016, but was less than FY 2015 when it issued 6.35 million decisions on medical issues. In March of 2013, VBA required roughly 282 days to process a claim. At the close of FY 2016, VBA reported that on average, it took 123 days to process a claim; however, in FY 2015, VBA reported that it took, on average, 92 days to complete a claim. In FY 2015, total inventory stood at about 352,000 claims; today VBA has a total inventory close to 400,000 claims. Furthermore, VBA has an inventory of nearly 584,000 for non-disability rating claims, such as for changes in dependent or marital status.

It will require a combined focus on technology and people to enable VBA to provide veterans and their dependents with more timely and accurate decisions. For FY 2018, the IBVSOs recommend an additional 1,750 FTEE to manage VBA's overall rising workload. Furthermore, since VBA stopped utilizing mandatory overtime for claims processing, the true need for additional personnel has become more evident. Of the overall increase in personnel, 1,000 FTEE would be dedicated to processing appeals pending at VBA in an effort to eliminate the backlog of 380,000 appeals in VBA over the next three years. Depending on progress this year, further personnel increases may be necessary to reduce the appeals backlog at VBA. In addition, 350 FTEE would be dedicated to addressing the growing backlog of non-rating related work, such as dependency claims. A further 300 FTEE would be dedicated for claims processing to address the incremental rise in the claims inventory and backlog and 100 FTEE would be dedicated to the Fiduciary program to meet the growing needs of veterans participating in VA's Caregiver Support programs. This recommendation is based on a July 2015 VA Inspector General report on the Fiduciary program that found, "...Field Examiner staffing did not keep pace with the growth in the beneficiary population, [and] VBA did not staff the hubs according to their staffing plan...."

VR&E Service Personnel **266 New FTEEs** **$32 million**

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

VR&E also operates its VetSuccess on Campus (VSOC) program at 94 college campuses.

Over the past few years, program participation has increased by 15 percent overall: increasing by 7.3 percent in FY 2015, 3.8 percent in FY 2016, and an estimated 4 percent in FY 2017. As VBA continues to expand VR&E eligibility to more veterans, due to increased claims processing and the award of new service-connected disabilities due to new presumptive disabilities, we project that total program participation for FY 2018 will grow by at least 5 percent for total caseload of close to 155,000.

Last year, Congress enacted Public Law 114–223, which authorizes the Secretary to use appropriated funds to ensure the ratio of veterans to full-time employment equivalents does not exceed 125 veterans to one full-time employment equivalent, a goal that VA has not met for years. In July 2015, VR&E reported that its average Vocational Rehabilitation Counselor (VRC)-to-client ratio had risen to 1:139. However, in both FY 2016 and FY 2017, the Administration flat-lined the VR&E request for direct personnel at 1,442. In order to achieve and sustain a 1:125 counselor-to-client ratio in FY 2018, we estimate that VR&E would need 266 new FTEE, for a total workforce of 1,550 FTEE, to manage an active caseload and provide support services to 155,000 VR&E participants. At a minimum, three-quarters, of the new hires should be VRCs dedicated to providing direct services to veterans. This increase in personnel would address expected growth in VR&E claim filings and program participation, as well as collateral duties performed by VRCs outside of general case management. It is also essential that these increases be properly distributed throughout all of VR&E to ensure that VRC caseloads are equitably balanced among VA Regional Offices.

GENERAL ADMINISTRATION

Board of Veterans' Appeals **$158 million**

Faced with a rising appeals backlog that could no longer be ignored, Congress last year authorized the Board of Veterans' Appeals (Board) to increase its FTEE by 242 over FY 2016 levels, bringing their total authorized staffing to 922 FTEE for FY 2017; the Board currently has only about 860 FTEE. For FY 2018, the IBVSOs recommend no additional increases in FTEE; however the Board must be permitted to hire their full complement of 922 FTEE. Further, as the number of claims processed annually continues to rise as a result of the increased capacity of VBA, the number of appeals filed annually will grow commensurately. In order for the Board to keep pace with this new incoming workload alone, not including those appeals already in the system, FTEE levels will have to be adjusted accordingly, though appeals reform legislation could alleviate some of that requirement in the future.

In the 114th Congress, significant appeals reform legislation was introduced. The legislative language reflected significant efforts of a working group formed in March 2016 that consisted of the IBVSOs, other VSO stakeholders, and leaders within VBA and the Board. This legislation would fundamentally reform and streamline the overall appeals process. Similar legislation (H.R. 457) has been introduced in the 115th Congress, however even if it is enacted, the Board will continue to require resources commensurate with workload, especially to process legacy appeals remaining at the time of enactment of new appeals reform legislation. Further, the Board must be funded and empowered to continue pursuing IT modernization solutions that best meet the specific workflow needs of the Board, while ensuring it also supports seamless integration with VBMS and other IT systems used by VBA and the Court of Appeals for Veterans Claims.

Mr. DENT. Thank you, Mr. Varela.

ADDING MORE VBA STAFF OR THE USE OF TECHNOLOGY

And just wanted to ask one question: The Independent Budget includes a large fiscal year 2018 request for more VBA staff. Do you feel that additional staff are the ultimate answer to keeping the disability claims backlog down, rather than the use of technology?

Mr. VARELA. They are symbiotic. They are both interrelated.

You are going to need—as we can see, VBMS has given the VA quite a lift in claims processing. They were able to keep processing record number of claims each year.

But in addition to that, while they were making those strides they diverted a lot of their workforce from the appeals workforce to process those claims. So what that tells you is that yes, you have the I.T. component that is helpful, but you still need the manpower as well, and these two things are interrelated.

Mr. DENT. Thanks.

I would recognize the ranking member, Ms. Wasserman Schultz.

HIRING FREEZE AND PROCESSING CLAIMS

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

Mr. Varela, given the administration's hiring freeze and your organization's position that staffing levels need to be addressed, how does the hiring freeze affect our ability to achieve that goal?

Mr. VARELA. It is my understanding that recently some positions within the Board of Veterans Appeals have been exempted so they can reach their full complement of 922 FTE. They probably won't get all of that, but they will get most of it.

Without the bodies to do the work, every day that is delayed in hiring new personnel to do the work is an extra day of delay in the claims and appeals process.

Ms. WASSERMAN SCHULTZ. So is it your impression that the claims process is negatively impacted by the hiring freeze?

Mr. VARELA. Yes, it is.

Ms. WASSERMAN SCHULTZ. Thank you.

Mr. DENT. Mr. Valadao.

Mr. VALADAO. Thank you very much for your service and for being here today.

TRANSITIONING SOLDIERS TO OBTAIN LICENSES AND CREDENTIALS

In the Independent Budget's agenda that you released this year you mentioned the need for Congress and the Department of Defense to work together to assist soldiers who are transitioning from civilian life to obtain occupational licenses and credentials. Recently the senior enlisted noncommissioned officers from each service testified before this committee and talked extensively about credentialing being one of their top priorities in helping prepare servicemen and women to transition to civilian careers.

Now, I know some progress has been made in the Department of Defense, but to your knowledge, has the VA been working with the services to assist with this issue? And in your opinion, how can

the VA work with the services and States to streamline the process for transitioning soldiers to obtain these licenses and credentials?

Mr. VARELA. I believe the VA has been very supportive of that cross-certification. What it really boils down to is the licensing and certification that you get in the service has to translate to what is acceptable within the States.

So it is going to be a matter of not just what we can do here with the VA—which they are very supportive of that; DAV also has a resolution that calls for Congress to enact legislation to make that happen—but we have got to get that to trickle down to the States for them to say, "Yes, that credentialing is acceptable," so that a nurse from the military can simply just come out of the military and be a nurse in any State.

Mr. VALADAO. And yes, you pointed out the States, but here at the federal level what do you think we can do to be of assistance to streamline that or—there is probably not a whole lot.

Mr. VARELA. Yes.

Mr. VALADAO. A lot of it falls on the State.

Mr. VARELA. Here at the federal level we have to ensure that Congress makes it a requirement for the DOD to say that, "You will outline your certifications to either match what is acceptable within the State or somehow establish those partnerships," you know, force them to say, "We need you to set up a program that allows those skills and credentials to be translated directly into the community."

Mr. VALADAO. Well, thank you.

And I yield back.

Mr. DENT. Thank you, Mr. Valadao.

Recognize Mr. Bishop.

Mr. BISHOP. Thank you.

Welcome, Mr. Varela.

The chairman emphasized—and, of course, I am equally concerned about the overall rise in the disability claims and the growing appeals claims backlog. And, of course, I agree with you that the I.T. investments will supplement and augment addressing that.

LIMITATIONS ON APPEALS WHILE THE RECORD IS SUBMITTED

But one of the things that the VA has recommended and I think the authorizing committees have been considering, with which I have had some concern, is that they want to limit the appeals and the opportunity for veterans to supplement the record while it is pending, once it has been submitted, which is another opportunity for veterans to provide more current medical information to bolster their claim. And, of course, the department has said that that adds to the backlog and that it makes it more difficult for them to alleviate that backlog.

So there is some tension there between making sure the veteran gets full consideration, and also expediting the appeals or the reconsideration. What is your view in terms of how to deal with that situation?

I have always, and I think the VA has historically, wanted to resolve that in favor of the veteran by allowing the veteran to submit any information at any time which would allow the more favorable consideration of their claim. How do you feel about that and the

legislation now that is moving forward that would limit the veteran's ability to do that?

Mr. VARELA. Okay. So there are two tracks there.

One is the current environment and a veteran's ability to submit evidence. In the current environment that has to be maintained because you are dealing with crucial benefits that can be awarded, effective date issues. And as you mentioned, sometimes it is not easy for veterans to come up with the evidence at a particular juncture, so they need to have an opportunity to submit that.

And we understand it is additional work for the VA, but it is work on behalf of disabled veterans. So that is where the efforts should be.

In the new environment, in this proposed new framework, there are still opportunities to submit evidence, particularly if a veteran wanted to go to the Board of Veterans Appeals. It is limited. We are working out the finer details and what happens if you submit evidence after that, but we are very comfortable that we will still be able to preserve that effective date to that filing and allow that evidence to be considered either at the board or at the VBA level.

Mr. BISHOP. Yes. That is what the rub is, and I don't quite know how to resolve that because my caseworkers have been able to supplement the records many times with medical evidence that the veteran didn't initially have or didn't submit and end up with a positive outcome.

But if they are cut off and shut out from being able to do that until after a decision is made then they have got to start all over again, which, again, is a protracted work for the VA as well as anxiety for the veteran.

Mr. VARELA. Yes.

Mr. DENT. Thank you, Mr. Bishop.

And, Mr. Varela, we appreciate your testimony and appearing before this subcommittee today. Thank you very much.

Mr. VARELA. Thank you, Mr. Chairman.

Mr. DENT. At this time I would like to invite Carlos Fuentes, director, National Legislative Service for the Veterans of Foreign Wars, VFW. So we welcome Mr. Fuentes, Carlos Fuentes, before us today.

And with that, you are recognized for 5 minutes.

WEDNESDAY, MARCH 29, 2017.

VETERANS OF FOREIGN WARS

WITNESS

CARLOS FUENTES, DIRECTOR NATIONAL LEGISLATIVE SERVICE

Mr. FUENTES. Chairman Dent, Ranking Member Wasserman Schultz, and members of the subcommittee, on behalf of the men and women of the VFW and our auxiliary, I do thank you for the opportunity to present our views on VA's budget.

I would like to first start by thanking you for your hard work last year on fiscal year 2017 appropriations. And because of your hard work, the MILCON–VA appropriations bill was the only one

to have completed regular order and, as a result, VA is the only department with full fiscal year 2017 appropriations.

Mr. DENT. Could you say that again? [Laughter.]

Mr. FUENTES. And we have seen the impact on the number of departments who are operating on the continuing resolution, and no other sticks out more than DOD. And I am sure you are also tracking that part of the military construction aspect of the jurisdiction.

Yet, those appropriations levels that were included in the conference report were more than $600 million short of the administration's request and significantly less than the Independent Budget recommendations. We know, however, that your ability to properly fund VA appropriations accounts are severely limited by outdated budget caps established by the Budget Control Act of 2011 and subsequent budget agreements.

The threat of sequestration and draconian spending cap limits our Nation's ability to provide servicemembers, veterans, and their families the care benefits they have earned. The VFW calls on this subcommittee to join our campaign to finally end sequestration and do away with federal budget processes based on arbitrary spending caps.

The VFW is glad to see President Trump has proposed a 6 percent increase in VA's fiscal year 2018 budget. However, we feel that the proposal falls a bit short.

And my colleague from PVA has described our recommendations for VA health care, and I would like to associate the VFW with those remarks.

I would like to focus my testimony on VA's need for capital infrastructure. For more than a decade the I.B. VSOs have warned Congress and VA that perpetual underfunding will allow—would allow VA infrastructure to erode while its capacity to meet demand has swelled from 81 percent in 2004 to as high as 120 percent in 2010.

The events of 2014 and subsequent access issues at VA health care facilities have illustrated how chronic underfunding of VA capital infrastructure and the lack of capacity to keep pace with demand has resulted in VA rationing care and veterans waiting too long for the care that they have earned.

The I.B. VSOs are working with VA to reform its construction process so facilities can be delivered on time and on budget. Previous errors must be corrected to ensure the issues that occurred in Aurora, Colorado never occur again. However, this subcommittee must not punish veterans who are awaiting desperately needed health care facilities because of the incompetence of bureaucrats who no longer work at VA

Currently, VA has 24 partially underfunded construction—major construction projects, which need a clear path to completion, some of which have been in the works for more than 12 years. VA's fiscal year 2017 priority list, which includes seismic corrections, cannot take a systemic pause while Congress and VA decides how to manage capital infrastructure long term.

VA will need to invest more than $3.5 billion to complete all 24 partially funded projects. Of the top five projects, many of them are seismic deficiencies and part of VA's core missions, such as mental health and spinal cord injury centers.

The I.B. VSOs recommend that Congress appropriate at least $1.5 billion for major construction in fiscal year 2018. This amount would ensure—will fund the next phase or fund through completion of the existing projects and begin advance planning and design development for VA's major construction projects.

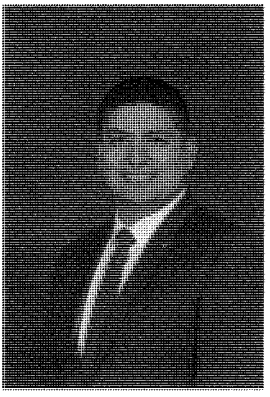
I would also like to quickly mention and thank the subcommittee, and especially Chairman Dent, for your leadership on expanding VA's fertility treatment options. VA, as we know, has announced that they will begin providing these treatments soon. However, the authority is limited and folks who—or veterans who aren't able to use assisted reproductive technology or adopt a child before the end of fiscal year 2018 will be left to bear the full cost of starting a family.

And these are severely disabled servicemembers who have lost their ability to reproduce due to their service, and we feel that that is unacceptable. We are working with the authorizing committees to make this authority permanent, but we ask that you continue to carry that authority into fiscal year 2019 and 2018 so that these veterans aren't left behind and that they continue to have that opportunity.

Mr. Chairman, thank you for the opportunity to testify. This concludes my remarks, and I am happy to answer any questions you or the members of the committee may have.

[The information follows:]

Carlos U. Fuentes
Director
National Legislative Service
Veterans of Foreign Wars of the United States



Carlos Fuentes is the Director of the National Legislative Service for the Veterans of Foreign Wars of the United States. It is his responsibility to plan, coordinate and implement the VFW's national legislative agenda with members of Congress, their staff and committees, and with other federal departments, agencies and organizations.

His mission is to work with Congress to create and protect the Quality of Life programs and services provided by the federal government to veterans, service members and their families, and to help defeat proposals that are not beneficial to America's veteran and military communities. This includes executing the VFW's Priority Goals, as it pertains to budgets, appropriations, health care, veterans' benefits and national security issues, as well as working on *The Independent Budget*, which is a comprehensive budget recommendation and policy document created by veterans for veterans.

Carlos served six years in the United States Marine Corps Reserve as a Civil Affairs Noncommissioned Officer. In 2009, he deployed to Helmand, Afghanistan, where he helped develop governmental infrastructure and contributed to humanitarian relief efforts in the war-torn region.

Prior to joining the VFW, he helped develop and pass veterans' health care legislation as a staff member on the Senate Committee on Veterans' Affairs from 2011 to 2014.

In 2012, Carlos received a Bachelor of Arts in Political Science with a minor in International Studies from The American University, Washington, D.C. He is a life member of VFW Post 5627 in College Park, Md.

He and his wife, Claudia Lainez, reside in Beltsville, Md.

March 14, 2017

VETERANS OF FOREIGN WARS OF THE UNITED STATES

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STATEMENT OF

CARLOS FUENTES, DIRECTOR, NATIONAL LEGISLATIVE SERVICE

VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE SUBCOMMITTEE ON

MILITARY CONSTRUCTION, VETERANS AFFAIRS AND RELATED AGENCIES

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

"Public Hearing"

WASHINGTON, D.C. March 29, 2017

Chairman Dent, Ranking Member Wasserman Schultz and members of the Subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I want to thank you for the opportunity to present the VFW's views on the Department of Veterans Affairs' (VA) Fiscal Year (FY) 2018 appropriations and Fiscal Year (FY) 2018 advance appropriations.

I want to thank this subcommittee for its hard work last year on VA's FY 2017 appropriations. The *Military Construction and Veterans Affairs and Related Agencies Appropriations Act* was the only appropriations bill to have completed regular order, and as a result VA is the only department with full FY 2017 appropriations. Instead of relying on a continuing resolution, VA is able to appropriately carry out its operating plans for FY 2017, implement new programs, hire new staff, and activate new facilities to improve the delivery of care and services to our nation's

veterans. However, the appropriation levels included in the conference report were more than $600 million short of the Administration's request and woefully short of the Independent Budget's (IB) recommendations. We know that your ability to properly fund VA's appropriation accounts is severely hindered by outdated budget caps established by the *Budget Control Act of 2011* (Public Law 112-25) and subsequent budget agreements.

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

The VFW, in partnership with our IB co-authors Disabled American Veterans (DAV) and Paralyzed Veterans of America (PVA), produces annual budget recommendations for each of VA's major funding accounts and compares them to the Administration's request. We are glad to see President Trump has proposed a six percent increase in VA's FY 2018 discretionary budget compared to FY 2017. However, we feel his proposal falls short of what VA needs to keep pace with demand for health care. PVA has detailed our recommendations and highlighted our concerns with the President's request to fund the Veterans Choice Program. The VFW shares those concerns.

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

The IBVSOs are working with VA to reform its construction process so facilities can be delivered on time and on budget. Previous errors must be corrected to ensure the issues in Aurora, Colorado, never occur again. However, this subcommittee should not punish veterans who are awaiting desperately needed health care facilities because of the incompetence of bureaucrats who no longer work at VA.

IB Recommendations for VA's Major Construction:

FY 2018 IB Recommendation — $1.50 billion

FY 2017 Appropriations — $528 million

Currently, VA has 24 major construction projects that are partially funded, some of which were originally funded in FY 2004, that need a clear path to completion. An additional three projects are in the design phase. Outside of the partially funded major projects list are major construction projects at the top of the FY 2017 priority list that are seismic in nature. These projects cannot take a strategic pause while Congress and VA decide how to manage capital infrastructure long-term. VA will need to invest more than $3.5 billion to complete all 24 partially funded projects. Of the top five projects on the priority list, two are seismic deficiencies, two support the core mission of VA — a mental health clinic and a spinal cord injury center — and one is an addition to an existing facility. The total cost of these five projects is $1.2 billion.

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

IB Construction Minor Construction:

FY 2018 IB Recommendation — $700 million

FY 2017 Appropriations — $372 million

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

In August 2014, the President signed the *Veterans Access, Choice, and Accountability Act of 2014* (Public Law 133-146). In this law, Congress provided $5 billion to increase health care access by increasing medical staffing levels and investing in infrastructure. VA has developed a spending plan that obligated $511 million for 64 minor construction projects over a two-year period.

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

The VFW would also like to thank this subcommittee, particularly Chairman Dent, for expanding fertility and adoption benefits for severely wounded veterans who have lost their ability to reproduce due to their service-connected injuries. VA recently issued an interim final rule to begin providing in vitro fertilization (IVF) options to eligible veterans. The VFW is glad to see VA has moved quickly and that eligible veterans will receive fertility treatments soon. VA also estimated that as many as 500 veterans and their spouses could receive adoption reimbursement or IVF services in FY 2018. However, these authorities are temporary and veterans who are unable to receive IVF or adopt a child by the end of FY 2017 will be left to bear the full cost of starting a family.

The IBVSOs will work with the authorizing committees to make this authority permanent, but we call on this subcommittee to ensure this important authority is included in any FY 2018 appropriations bill that is considered. Veterans who lost their ability to reproduce due to their military service deserve the opportunity to achieve their dreams of starting a family. Please do not pull the rug out from under them simply because the authorizing committees have failed to make these severely disabled veterans a priority.

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

Mr. DENT. Thank you, Mr. Fuentes, for your testimony, and thank you, too, for your kind words about the in vitro fertilization, IVF, provision that was included. A lot of people were very interested in that—Mr. Larsen I know, Ms. Brownley, Mrs. Roby, and many others all, you know, were very strong advocates. So thank you for your good words on that.

INFRASTRUCTURE NEEDS WHEN NON-VA CARE IS INCREASING

Also, just wanted to highlight the enormous infrastructure needs of the VA and how it is struggling, given all the aging buildings and the shifting veteran population. We know that last year the VA calculated its infrastructure shortfall as being as high as about $50 billion. Setting aside the problem that we are unlikely to be able to provide the funding required, is it appropriate to continue to plan a massive VA infrastructure effort when VA is increasing its use of non-VA care that uses private facilities?

Mr. FUENTES. What we want to make sure is not forgotten or ignored when discussing the Choice program and Community Care is VA's ability to provide direct care, right? We have 80 percent of the VFW's membership relies on VA for their health care, and the community is part of the solution.

As we increase VA's funding for Community Care we cannot ignore its medical services appropriation and the impact that construction has on VA's ability to meet the needs.

The lack of funding for VA's capital infrastructure has really resulted in a lot of these wait-time issues because it takes way too long for VA to construct these facilities. We need to reform its capital infrastructure process, but we can't ignore that they need the funding to continue to expand.

Mr. DENT. Ms. Wasserman Schultz.

Ms. WASSERMAN SCHULTZ. Thank you.

IN VITRO FERTILIZATION

Just to underscore your point about in vitro fertilization and other assisted reproductive technologies, for those unfamiliar with the process—and I won't go into any of the details, but it often does not work the first time, particularly for individuals who have a service-related injury and whose infertility is caused by their service or their injuries.

So leaving it in place just for one fiscal year and having it expire would be devastating to people who are in the midst of a fertility cycle because these are—this is a process that, as you go through it, is dependent on nature's timing, not our fiscal year calendar.

So it is really important that we make sure that we don't cut off the access to procedures that our service-related injured veterans might be in the midst of, denying them the opportunity to start their families.

So I don't have a question. I just want to make sure you know you have my support.

Mr. DENT. Thank you.

Mr. Taylor.

Mr. TAYLOR. Thank you, Mr. Chairman.

And thank you again for your service and your advocacy, and yours as well, too. Go Navy. And I am Post 392. Thank you. Lifetime member.

MENTAL HEALTH CARE AWARENESS INITIATIVES

Quick question. Two things. First, you were mentioning spinal cord injuries. I didn't hear you talk about TBI or PTSD. Can you just mention if there are any initiatives with VFW and what you are supporting for increased help in those arenas?

Mr. FUENTES. Sure. My testimony, as a co-author of the I.B., focused on the infrastructure needs of VA, but we certainly have made mental health care awareness a priority for the VFW this year.

Our national commander actually launched a campaign to really change the direction and the narrative around mental health because there is a stigma around mental health where veterans fear going to receive the mental health care that they need. And it is really just as any other type of health or any other body part, it needs to heal. You need treatment to get better.

So we certainly support expanded mental health care services and also believe that there is this need for outreach in order to really de-stigmatize mental health.

Mr. TAYLOR. Thank you.

USE OF VA VERSUS COMMUNITY CARE

So with the understanding that there is a shortfall in the construction budget and construction plays a big impact, potentially, on wait times; also with the understanding that the VA, of course, is responsible for our veterans' care, does the VFW support more use of private care, whether it might be redundancies or duplication of primary care services, for example, where there are private facilities that are right there? Not, of course, the injuries that are unique to veterans, but other private care that is accessible and easily accessible. Do you guys support that or are you are saying no?

Mr. FUENTES. Yes, we do.

So just to be clear, VA needs to really conduct a manpower capacity analysis in each community. Health care is local—you know, there are areas in the country where it will take 6 months in the private sector to receive a dermatology appointment. In other areas like San Diego it is more readily available.

So VA needs to see what the demand is for veterans in each community and see what its capacity to meet that demand, but also incorporate the private sector, but other public health care facilities like DOD, Indian Health Services, and federally qualified health centers, so to take that integrated approach so you are not duplicating and you are leveraging the best capacities in that community.

Each community is going to look different. So sometimes there may be more private primary care, and in other areas private primary care may not be readily available so VA will have to build that.

Mr. TAYLOR. Thank you.

Thank you, Mr. Chairman.

Mr. DENT. Thank you, Mr. Taylor.
Mr. Bishop.
Mr. BISHOP. Thank you very much.
Again, welcome, to you, Mr. Fuentes.

CONSTRUCTION OF RESEARCH FACILITIES

I am sure that Ms. Kelly will probably touch on this when she testifies, but I would like to know what the VFW's position is with regard to the construction of research facilities.

In 2012, at the request of Congress, the department Office of Research and Development did an in-depth study and an analysis of the physical condition of the VA's aging research infrastructure, and they reported that the average VA building that houses research laboratories is over 50 years old.

Of course, the American Psychological Association argues that VA lacks the state-of-the-art research facilities and that modern research can't be conducted in facilities that closely resemble a high school science lab.

As a result, they are recommending $50 million for five major research facility construction projects and $175 million for minor construction maintenance projects. What is VFW's position on that? Do you support that analysis and that request, in light of the other request for major construction that is a lot more expensive?

Mr. FUENTES. We fully support. Research is one of VA's four core missions, and you are absolutely right. I have also visited some of those research facilities that are out of date.

You know, fortunately there are some that you see as an examples of what state-of-the-art research facilities should look like and, as a result, you see VA making a lot of progress and really leading the industry, in many respects, when it comes to research when they are given the proper tools. And that just speaks to, again, the lack of attention and, frankly, resources devoted to VA's capital infrastructure.

Again, not ignoring the fact that we need to make sure that buildings are delivered on time and on budget, but the need for resources cannot be ignored.

Mr. DENT. Thank you, Mr. Bishop.

And, Mr. Fuentes, we thank you for your testimony. We really appreciate all that you are doing. Thank you very much.

Mr. FUENTES. Thank you, Mr. Chairman.

Mr. DENT. At this time I would like to call to the witness table Dr. Heather O'Beirne Kelly. She represents the American Psychological Association.

Dr. KELLY. Good morning, Chairman Dent.

Mr. DENT. Dr. Kelly, welcome, and you are recognized for 5 minutes.

WEDNESDAY, MARCH 29, 2017.

AMERICAN PSYCHOLOGICAL ASSOCIATION

WITNESS

DR. HEATHER O'BEIRNE KELLY, DIRECTOR VETERANS AND MILITARY HEALTH POLICY

Dr. KELLY. Thank you.

Chairman Dent, Ranking Member Wasserman Schultz and members of the subcommittee I am Dr. Heather Kelly, a psychologist and director of veterans and military health policy at the American Psychological Association. I also come from a family of career military officers and combat veterans, so I do care deeply about these issues of veterans care, both personally and professionally.

As you may know, APA is our country's largest scientific and professional organization, with more than 115,000 psychologists. And the Department of Veterans Affairs, or the VA, is the largest single employer of psychologists.

VA's psychologists work both as research scientists and clinicians committed to improving the lives of our Nation's veterans. As the largest provider of training for psychologists, the VA also plays a vital role in equipping the mental health workforce to provide culturally competent and integrated mental health services to veterans and their families.

I have provided more detail in APA's written testimony, so I would like to focus on three priority areas today and get to Congressman Bishop's question in particular, and I would like to also echo the priorities of my VSO colleagues who have gone before me. We agree on all of the same issues and, in fact, we were one of the members who co-wrote the research section of the I.B.

So, Congressman Bishop, we thank you for mentioning our concerns about research facilities, and that is also echoed in the Independent Budget. You are not going to attract the highest-quality psychologists, particularly who are often both researchers and clinicians, to the VA unless they can do their research in facilities that at least have computers. We are not even talking about really high tech in some cases, but really that have desks and computers. So thank you for calling attention to that issue.

So the three priority areas I would like to focus on are VA research, clinical care for veterans, and the scope of practice for VA psychologists.

In terms of research, APA joins the Friends of VA Medical Care and Health Research coalition, or FOVA, in urging the subcommittee to provide $713 million in fiscal year 2018 for VA medical and prosthetic research. As my colleagues have mentioned, a strong VA psychological research program provides the scientific foundation for high-quality care within the VA system, which is absolutely vital for serving veterans suffering with post-traumatic stress disorder, PTSD; traumatic brain injury, or TBI; substance abuse; aging-related and other disorders requiring physical and psychosocial rehabilitation; and, of course, suicidal ideation.

We have better treatments now for all of these issues because of your prior investments in VA intramural research, and we desperately need to further advance our knowledge of these signature wounds of war to alleviate veteran suffering—and not only to alleviate suffering, but to help them regain lives of purpose and of joy.

In terms of clinical care, APA echoes the many concerns and suggestions of the VSOs regarding VA mental health services outlined in their Independent Budget, as I have mentioned. We also share VA Secretary Shulkin's recently announced priorities related to en-

hanced suicide prevention efforts, extension of mental health care to veterans with other-than-honorable discharges, and expansion of caregiver benefits to include pre-9/11 veterans' families.

These were the initiatives, as you, I am sure, know must come with more resources to be implemented. If you open the doors wider, you need more money to serve those people whom you have invited in.

We urge Congress to provide ample resources for VA mental health programs and the VA psychologists who serve veterans through increased hiring of VA psychologists—and I would ask that we finally make the move and move psychologists into the Title 38 hiring authority; by holding community partners and contractors to the high standards of quality assessment and care that exist in the VA; increasing support for primary care mental health integration models and telemental health services; and replacing the scheduling package in the electronic medical record. All of these are critical for improving patient experience and patient care within the VA.

And finally, within the terms of the VA psychologists' scope of practice and improving mental health care access at the VA, I strongly urge you to direct the VA secretary to grant specially trained VA psychologists prescriptive authority analogous to that granted by the Department of Defense almost 20 years ago. DOD has had zero adverse effects or complaints reported during that entire period, and if any of you are familiar with health care, zero adverse effects and zero complaints are unheard of.

DOD psychologists—medically prescribing psychologists—have served thousands and thousands of active duty military personnel. This is another safe, effective way to increase mental health care access, and the VA is behind in granting this authority to appropriately trained psychologists.

I should mention, these are psychologists like me, who have master's degrees and Ph.D.s and then go out and get a separate master's in pharmacology on top of their existing M.A. and Ph.D. These are really well-trained psychologists and the only doctoral-level professionals in the VA who do not have prescribing authority.

As I mentioned, VA is behind in granting this authority, and behind not only DOD but behind States like Louisiana, behind territories like Guam, and behind the tribal reservations of Indian country in granting this prescribing authority.

A veteran in Pennsylvania, a veteran in Florida, a veteran in Georgia, a veteran in Virginia should have access to the same high-quality mental health care as a nonveteran in Louisiana or Guam.

And remember that the power to prescribe is also the power to un-prescribe medication, which is a particularly important issue facing both civilian and veteran populations across the country.

So I urge you to direct the secretary at the very least to begin with a pilot program in VA, particularly in VA medical centers with the most dire mental health care access needs, and those tend to be the rural areas.

In conclusion, the VA, in the face of increasing demand for mental health care and recognized access difficulties in rural areas in particular, must remain a pioneer in the health care arena by allowing specially trained and certified psychologists to work at the

full scope of their practice and to serve veterans with the expertise and dedication they already employ.

Thank you for the opportunity to testify, and I am happy to answer questions.

[The information follows:]

Brief Bio for Heather O'Beirne Kelly, PhD

Heather O'Beirne Kelly is a senior legislative and federal affairs officer in the Science Government Relations Office of the American Psychological Association, a post she has held since 1998. In this role, Dr. Kelly advocates for behavioral science on Capitol Hill and in federal agencies and directs APA's Executive Branch Science Fellowship Program. Within her advocacy portfolio are the psychological research programs within the Department of Defense, the Department of Veterans Affairs and the National Science Foundation. She also is the team leader for all of APA's military and Veteran-related issues. Dr. Kelly sits on the Executive Committee of the Friends of VA Medical Care and Health Research Coalition; represents APA on the VA Office of Mental Health Services Stakeholders Group; has testified before Congress regarding funding for VA research and mental health services; and has coordinated numerous Capitol Hill briefings on topics of interest to the veteran population, including suicide prevention, PTSD, and traumatic brain injury.

Dr. Kelly graduated from Smith College in 1987 and worked in non-profit development for clients including the Children's Defense Fund, UNICEF and the March of Dimes before becoming director of corporate relations for Wolf Trap Foundation for the Performing Arts in 1989.

Dr. Kelly received her doctorate in clinical psychology from the University of Virginia in 1998, where she taught both undergraduate and graduate courses in psychology. She completed her pre-doctoral clinical internship at Children's Hospital in Washington, D.C. Dr. Kelly's research focused on adolescent social development, child sexual abuse and adolescent dating violence. As a therapist, she worked primarily with children and families.

American Psychological Association
Testimony Submitted March 17, 2017
By Heather O'Beirne Kelly, PhD

to the
United States House of Representatives
Committee on Appropriations
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies

Fiscal Year 2018 Appropriations for the Department of Veterans Affairs

The American Psychological Association (APA) is a scientific and professional organization of more than 115,000 psychologists and affiliates. The Department of Veterans Affairs (VA) is the largest single employer of psychologists, who work both as research scientists and clinicians committed to improving the lives of our nation's veterans. As the largest provider of training for psychologists, the VA also plays a vital role in addressing the mental health workforce shortage equipped to provide culturally competent and integrated mental health services to veterans and their families.

REQUEST SUMMARY:
Research—APA joins the Friends of VA Medical Care and Health Research (FOVA) coalition in urging Congress to provide **$713 million in FY2018 for VA Medical and Prosthetic Research.** APA also encourages the Subcommittee to provide at least **$50 million for up to five major construction projects in VA research facilities and $175 million in nonrecurring maintenance and for minor construction projects** to address deficiencies identified in the independent VA research facilities review provided to Congress.

Clinical Issues—APA urges Congress to take specific actions outlined below to enhance access, continuity, and integration of mental healthcare in the VA; track and improve the quality of non-VA care; and address recruitment and retention challenges for VA psychologists.

Psychological Research in the VA

A strong VA psychological research program provides the scientific foundation for high-quality care within the VA system. Through its Medical and Prosthetic Research Account, the VA funds intramural research that supports its clinical mission to care for veterans. VA psychologists play a dual role in providing care

for veterans and conducting research in all areas of health, including high-priority areas particularly relevant to veterans, such as: mental health and suicide prevention, traumatic brain injury (TBI), substance abuse, aging-related disorders and physical and psychosocial rehabilitation. VA psychologists are leaders in providing effective diagnosis and treatment for all mental health, substance use and behavioral health issues. In addition, VA psychologists often receive specialty training in rehabilitation psychology and/or neuropsychology, which helps to improve assessment, treatment, and research on the many conditions affecting veterans, including: post-traumatic stress disorder (PTSD), burns, amputation, blindness, spinal cord injuries and polytrauma. Equally important are the profoundly positive impacts of psychological interventions on the care of veterans suffering from chronic illnesses such as cancer, cardiovascular disease, HIV and chronic pain.

VA psychologists continue to be at the forefront of cutting-edge research on, assessment of and treatment for PTSD, a particular concern within the VA and Congress. The care of veterans suffering psychological wounds as a result of military service is at the heart of the VA's mandate "to care for him who shall have borne the battle," and preventing and treating PTSD has become an even more important priority within the VA given the needs of veterans from recent conflicts overseas. VA psychologists are responsible for the development of the most widely respected and used diagnostic instruments and therapeutic techniques for assessing and treating PTSD. The current conflicts present new challenges for VA psychologists, as many veterans with PTSD have post-concussive symptoms stemming from blast injuries. Additional research is needed to develop novel treatments for PTSD in cases when cognitive problems also may stem from a history of documented TBI.

VA psychologists also have used their expertise in program development and evaluation to successfully improve the VA's coordinated service approach. This includes models and practices of care that encompass inpatient, partial hospitalization and outpatient services including psychosocial rehabilitation programs, geriatric services in the community, and homelessness programs. VA psychologists have initiated and evaluated innovative programs, such as tele-mental health services, that will dramatically expand the VA's continuum of care for veterans.

To keep VA research funding at current-services levels, the VA research program needs at least $19 million (a 2.8 percent increase over FY 2017) to account for biomedical research inflation. However, the FOVA organizations believe an additional $19 million in FY 2018, beyond inflationary coverage, is necessary for sustained support of research on conditions prevalent among OIF and OEF veterans as well as chronic conditions of aging veterans. While FOVA supports $65 million for the VA's Million Veteran Program (MVP) to advance precision medicine, this program should not impede other critical VA research priorities.

VA Research Facilities Upgrades

State-of-the-art research requires state-of-the-art technology, equipment, and facilities in addition to highly qualified and committed scientists and investigators. Modern research cannot be conducted in facilities that more closely resemble high school science laboratories than university-class space. Modern facilities would also help VA recruit and retain the best and brightest clinician-scientists. In recent years, funding for the VA minor construction program has failed to adequately provide the resources needed to maintain, upgrade, and replace aging research facilities. For the most part, research facilities have competed unsuccessfully with other VA facility needs for basic infrastructure and physical plant improvements. Many VA facilities have run out of adequate research space. Also, ventilation, electrical and water supply, and plumbing appear frequently on lists of needed upgrades along with space reconfigurations. In addition to impeding medical discovery, poor research infrastructure undermines the ability of the VA to recruit and retain the clinical investigators who would normally be drawn to the VA system for its unique research opportunities.

APA and FOVA have appreciated the Subcommittee's attention to this issue in prior years, but the problem lingers. For decades, the VA construction and maintenance appropriations have failed to provide the resources VA needs to replace, maintain, or upgrade its aging research facilities. Consequently, many VA facilities have run out of adequate research space, or existing space is unable to meet current standards. FOVA believes designating funds to specific VA research facilities is the only way to break this stalemate. We encourage the Subcommittee to provide at least $50 million for up to five major construction projects in VA research facilities and $175 million in nonrecurring maintenance and for minor construction projects to address deficiencies identified in the congressionally requested report on the status of VA research facilities (H.Rept. 109-95, H.Rept. 111-559), available at www.aamc.org/varpt.

VA Mental Healthcare

APA echoes the many concerns and suggestions of Veterans Service Organizations (VSOs) regarding VA mental health services outlined in their policy recommendations (the Independent Budget Veterans Agenda or IB). We also share VA Secretary Shulkin's recently delineated priorities related to enhanced suicide prevention, extension of mental healthcare to Veterans with "other than honorable" discharges, and expansion of caregiver benefits to include pre-9/11 Veteran families. We also urge Congress to provide ample resources for VA mental health programs and the VA psychologists who serve Veterans, with special attention to the following requests:

Prevent Veteran Suicide by enhancing access, continuity, and integration of care by:

- Continuing and increasing support for primary care-mental health integration and recovery models;
- Continuing support for expansion of telemental health services;
- Granting specially-trained psychologists prescriptive authority analogous to that granted by the Department of Defense for almost 20 years, which will alleviate mental healthcare access issues;
- Building on the success of evidence-based psychotherapy roll-outs;
- Guiding treatment decisions by measuring the effects of interventions, and developing systems for measurement-based care for use by both VA staff and VA partners; and
- Replacing scheduling package and upgrade electronic medical record, critical for improving patient experience and care.

Track and Improve Quality of Non-VA Care by:

- With increased non-VA care services being supported, assuring that non-VA providers are competent in Veteran-specific needs and Veteran culture, and are consistently providing high-quality care;
- Holding community partners and contractors to the high VA standards of quality; and
- Providing (and consistently enforcing) standard guidelines regarding what constitutes and how much time is required for a high-quality compensation and pension evaluation.

Address Recruitment and Retention Challenges for Psychologists by:

- Moving VA psychologists into full Title 38 authority, consistent with all other doctoral level VA staff, in line with Secretary Shulkin's goals to improve accountability, hiring, and retention;
- Providing VA psychologists with improved incentives (particularly loan repayment) to attract strong candidates; and
- Expanding opportunities for staff training in state-of-the-art interventions, and removing barriers to conference attendance.

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PREVENTING VETERAN SUICIDES

Mr. DENT. Thank you, Dr. Kelly, for your testimony. We very much appreciate your being here.

I only have one quick question. In our hearing last week with the VA inspector general we heard about the problems with the VA suicide hotline.

Dr. KELLY. Yes.

Mr. DENT. More generally, I guess, how does your association think the VA is doing in its efforts to prevent veteran suicide?

Dr. KELLY. In general, VA mental health care is superior to any other mental health care anywhere in the world. I have veterans in my family, and if they had mental health issues I would send them immediately to the VA.

So in general, superior care. All the reports coming out of RAND and other reports you have seen, VA mental health care is either equal to or superior to that you can get often in the civilian sector.

Suicide prevention is as important as it is difficult. It is a very low base rate behavior that we desperately want to prevent, and I would say that VA has made remarkable strides into lowering the rates of veterans who come to the VA for their mental health care. The suicide rate for veterans who get care outside of the VA is much higher, so we want them to come to the VA for their care.

There are issues with the suicide hotline that need to be resolved. There are issues with access more than with the quality of VA mental health care, so if we can increase access—and there are a variety of ways to do that; pulling apart the VA's integrated system is not one of them.

We are watching very carefully the hotline in particular. I think most of the issues have actually been with the civilians who call the prevention line and are more often put on hold than the veterans.

So we have issues with the suicide hotline in general, but are watching it very carefully. And I think they are being taken very seriously by the VA.

Thanks.

Mr. DENT. Thank you, Dr. Kelly.

Ms. Wasserman Schultz.

TRAINING FOR CRISIS HOTLINE

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

Just to follow up on the chairman's line of questioning, we did extensively ask the I.G. questions about problems with the crisis hotline, and training appears to be one of the significant obstacles that they have.

Have you given them any guidance on how they can improve their training? What it appears is that there is very inconsistent training from the national hotline to the local crisis lines that are housed at each medical center.

Dr. KELLY. And that is a classic issue, frankly, and there are a couple things I would like to say about that. One is it may seem unrelated, but some of the restrictions on federal employee conference attendance and travel have actually affected VA training rather substantially, and so anything you all can do to get rid of

the restrictions on federal employees of all kinds, but VA federal employees, traveling—there were things in Florida happening where a number of psychologists were hired a couple of years ago by the VA and weren't allowed to travel six miles down the road in their own car for the mandatory new mental health training.

So there are some really crazy ramifications of some of those rules, so I am not surprised that training is an issue.

Part of what you all need to know we are all struggling with is that VA has always provided community care, and this is an issue of care when more people in the communities are staffing those hotlines. It is very important that all community partners be trained and held to the same standards of assessment and care as VA staff and mental health professionals are, and right now that is not the case.

And so I echo your concern about training and maintaining and assessing quality of care.

TRAINING THAT VA PROVIDES VERSUS PRIVATE SECTOR TRAINING

Ms. WASSERMAN SCHULTZ. And speaking of training, that was actually my next question in terms of the difference in training that the VA provides versus the private sector training.

Are they comparable? You alluded now that they are not. Where would you think there need to be improvements on the VA side of training, or is the VA already superior, not just on the crisis line, but across the board?

Dr. KELLY. Thank you. It is a great question and one that we are really involved in trying to tackle, because obviously at the American Psychological Association, I am in charge of the side that deals with military and veteran populations, but we certainly care very much about our civilian providers.

This civilian-military divide—this is one of the places where it shows. And so we have been very involved with partners like PsychArmor, the VA itself, who have a number of modules of training in military culture and veteran cultures, thorough, that have been developed and vetted and provided for free to civilian providers. PsychArmor now has MOUs with all of the major health care providers—civilian health care providers and offers corporations, staff, counseling centers at colleges training in military culture and veterans culture for that exact reason, is to begin to bring some of the civilian providers at least some more competence in that area, which is completely separate from some of the things you have seen, again, in some of the RAND reports.

"Ready to Serve" is the most important recent report showing that even on some of the evidence-based psychotherapies, which APA obviously recommends for treatment, in particular with PTSD and depression and anxiety, civilian providers are behind VA providers in their provision of evidence-based mental health care. And so when we talk about moving veterans into getting more community care, I have very deep concerns about the quality of the care that they would receive there.

And so we are working very hard to make sure that any relationship that the VA has with community providers must entail training and assessing and constant monitoring of that care in the com-

munity to make sure that our veterans are getting the quality of care that they deserve.

Ms. WASSERMAN SCHULTZ. Thank you.

Mr. DENT. Mr. Taylor.

Mr. TAYLOR. Thank you, Mr. Chairman.

Thank you for what you do and all those degrees that you got. [Laughter.]

Thanks a lot. We really appreciate it.

LACK OF UNIFORMITY IN SUICIDE PREVENTION POLICIES

Quick question along the lines of the suicide hotline. That is something that has been talked about, but one of the other things that we talked to the I.G. with, that my office actually has requested a report on is not just the suicide hotline but the physical walkups, people come to the facilities and say, "Look, I am suicidal," or they exhibit those tendencies or something like that, and the non-uniform-type policy with the VA. One of the things that the I.G. said was that there is decentralized across the whole VA spectrum.

Has APA helped with that in terms of trying to create a uniform policy for the VA across everywhere that says anyone who comes in, that they are not turned away and the unfortunate thing happens, potentially?

Dr. KELLY. Yes. I have been very vocal—Dr. Shulkin will tell you—with him personally and with his staff for many years on this issue in his previous role and now in his current role. My understanding is that any veteran who calls or appears at a VA medical center with urgent self-harm or harm-to-others concerns will be seen immediately.

There are some metrics there that we are watching very carefully—that is supposed to be true of all VA medical centers. I am not sure if they have reached that at this point. But same-day urgent care absolutely is the standard that VA is looking to meet.

And I think sometimes the issue—two things: One, that is precisely why you also want the primary care mental health integration. You want someone who is much more likely to walk up into an E.R. or to come through primary care to get automatic assessment.

You know, a lot of these people are not going to tell you—some will, but some won't tell you and a really quick but really careful diagnostic assessment of anyone that comes in—frankly, we find out about suicidal behavior much more often by asking about sleep issues and some other concerns. I mean, it is the gateway into a lot of health care problems for veterans in particular.

So we want psychologists in most VA facilities—in all of the big ones, and we are trying to make sure it goes all throughout the VA. There are psychologists embedded in primary care for those reasons of stigma that you have heard about. You know, someone doesn't have to walk to another floor with a door that says "mental health" above it, but literally gets a warm handoff to a physician or a psychologist standing right there to talk about those issues.

So same-day access is vital, and I think it is certainly a VA standard.

What is often the issue is the second appointment, so how quickly can that veteran then be seen, depending on what the diagnostic assessment is, for the next kind of care—if it is outpatient, for the next level of outpatient care? There are never enough inpatient beds anywhere in the entire U.S. health care system, but in the VA also we need more inpatient beds for psychiatric issues.

But certainly same-day access, and this is an issue I work on every day with the VA and the VA psychologists in particular.

Mr. TAYLOR. Thank you very much.

And just we would love to speak with you offline about the pilot program. So thanks. Thanks a lot.

Dr. KELLY. Thank you.

Mr. DENT. Thank you, Mr. Taylor.

Mr. Bishop.

Mr. BISHOP. Thank you very much.

And, Dr. Kelly, thank you so much, and we appreciate your insights as well as your level of training, particularly in pharmacology.

Dr. KELLY. Well, I didn't go get the extra one in pharmacology. My colleagues have, but I can talk to you but I can't give you any medication.

Mr. BISHOP. Okay. That level of training and becoming a pharmacologist is probably unique among the VA psychologists——

Dr. KELLY. Yes.

Mr. BISHOP. We, at the committee, have to deal with the tension between scope of practice issues, the professional associations and the VA, that often has difficulty getting the high-level professionals in the specific disciplines. And so the prescribing authority that you recommended sometimes brings us into conflict with the professional associations, the M.D.s, the medical doctors who say that, "No, no, they don't need to have that."

And so we get in the middle between what is the best care for veterans and what will protect veterans, versus what is most convenient and most economical for the VA. So that is something that we need your help in dealing with.

CARE FOR SEXUAL ASSAULT VICTIMS

But I wanted to explore another issue with you, particularly as a psychologist. We are now experiencing the first generation of women who have served in combat roles, and many of them will return home with the same psychological scars as men.

But according to the Department of Veterans Affairs, women have a higher risk of exposure to sexual harassment and sexual assault than men, which may lead to trauma. Furthermore, many of the women will be in their teens and their early 20s when this happens.

In your opinion, is the VA adequately postured to ensure that there is adequate access to quality care for women veterans to deal with these myriad of issues that they will be experiencing in escalating numbers going forward?

Dr. KELLY. Let me touch on your first question and then your second.

In terms of the first question and the turf issues between medicine and other disciplines for whom prescribing authority is appro-

priate and the fullest extent of our practice, I will tell you what I told a young staffer who was trying to work with me on this issue: Regardless of what you may hear from the medical societies, many of whom have been supportive of our prescribing authority in the States, in Illinois in particular, I refuse to do turf battles over people who have served in actual battles.

So that is something that people in associations need to get over and deal with, and I care about what care the veterans get. And if you have a psychologist in the Department of Defense who can prescribe medication and other kinds of therapy—which are always going to be the first attempt for us; we are never going to go to medication first, and that is something I think that is incredibly valuable—they can walk across the hall in El Paso from seeing a DOD psychologist and can't see a VA psychologist once that member is now a veteran who can provide the same service. That doesn't make any sense to me.

But the turf battles are purely that, and we need to get over that.

In terms of the second question, much more serious question of sexual assault and sexual harassment in the military for both men and women, but because women are increasing in numbers and increasing percentage of the services and now the veteran population, it is a massive problem and we are very concerned about it.

In terms of the VA's capacity to handle, I have seen great strides in terms of their establishment of the women's office. They have women's research programs going that are just exquisitely set up. So I am very impressed with what I see.

Certainly, you know, women veterans' suicide rates are much higher than the cohort of women in the civilian population, which should not be a surprise to us. Most people who die by suicide die with guns, and women civilians don't tend to have guns or be as accurate with guns, and women veterans are because that is the nature of their work.

So we have our work cut out for us to address the issue of guns and suicide in the veteran population very directly without being shy about it. I think that the VA is making some strides in that area as well, but women veterans need more access, just like any other issue, be it fertility-related or mental health-related. Those are often interrelated.

There need to be enough mental health professionals within the VA to see them, and so it always comes back to just the staffing level.

Mr. BISHOP. Thank you.

Dr. KELLY. Thank you.

Mr. FORTENBERRY [presiding]. Thank you, Dr. Kelly.

I am Congressman Fortenberry from Nebraska and I am pinch-hitting for the chairman for a moment, but I have a question, as well. Before I enter it in mind, you said sexual assault is a massive problem. Would you unpack that a little bit more, please?

Dr. KELLY. So in the civilian population and the veteran population, certainly rates of sexual harassment are quite high and sexual assault I think is on the minds of many of us, in particular in relation to the military with some of the issues going on on the online issues that we are facing.

Mr. FORTENBERRY. With the appropriate attentiveness to this problem and the growing awareness, and the creation of infrastructure and policy to deal with this more directly, do you think that this is declining or is it still in a phase where we do not have appropriate management of this grave problem?

Dr. KELLY. So as a good scientist I am loath to go beyond the data. I would say I don't see it declining. I think you see more——

Mr. FORTENBERRY. Why is that?

Dr. KELLY. I think there are multiple reasons for that, one of which is it is hard to detangle sometimes whether the actual incidence is increasing or whether people are reporting and feeling more comfortable reporting. It is hard to untangle that.

Mr. FORTENBERRY. That actually could be progress, even though it shows as a statistically higher increase, the progress that this is——

Dr. KELLY. It could be. It could be. And we have ways of addressing that.

Mr. FORTENBERRY [continuing]. The culture is creating mechanisms for reporting and decreasing inhibitions.

Dr. KELLY. I hope that that is the case. I hope that it is solely an increase in reporting. I would not stake my expertise on that.

I think it is a particular issue, and I think that women veterans that, anecdotally with whom I talk—and male veterans who are sexually assaulted—this is a population that is hardy and tough and they want to keep doing their jobs.

I come from a military family. I understand the hierarchy; I understand the need for it. All of those issues provide a context in which coming forward is very, very difficult, and the more we can do to set up infrastructure such that commanders deal with that appropriately, the more that I think we will see it dealt with appropriately.

Mr. FORTENBERRY. In this regard, you mentioned that women veterans suicide rates are higher than nonveteran populations. Are their suicide rates higher than male veteran populations?

Dr. KELLY. I would have to look at the data on that and by age, because suicide has sort of a bimodal activity, more likely in the young and more likely in the old. I would have to look and see for women veterans if their rate is higher than their male veteran counterparts.

I do know that it is significantly different from women civilians of their same age.

Mr. FORTENBERRY. And then the correlation to a culture that, as you are saying, as we know, has had difficulties with the issue of sexual assault, there has got to be a variable there that is significant, I would think.

Regarding sleep, I was interested to hear you say that. I was talking with—actually, there is a psychologist here in the House who is a member of the military and he has counseled commanders who have sometimes, in terms of punishment, increased the duty and assignments on young people that create a cycle of a lack of sleep and then suddenly we are into deeper problems. And his first recommendation is, "Go to bed."

Dr. KELLY. Yes.

Mr. FORTENBERRY. "Talk to you in 2 days."

Dr. KELLY. Yes.

Mr. FORTENBERRY. I thought that was very insightful, and I think that even medical school training is shifting in this regard.

Dr. KELLY. I was just going to say the analogy between training physicians in particular—you know, my dad was a nuclear submariner, and one of Rickover's boys, and the lack of sleep standing duty on subs is just immense, but we do the same thing to our physicians. And the results are life-or-death sometimes.

Mr. FORTENBERRY. Maybe we should make note of that here in Congress, as well.

Dr. KELLY. Yes.

Mr. FORTENBERRY. Adequate rest.

Finally, I have been working with an outside entity that really has a fascinating project. There is a pilot project going on. Their outcomes are measurable in terms of the increase in wellness, the reductions in mental health stress, plus harder-to-define outcomes such as feeling a sense of belonging to your community for wounded veterans, disabled veterans participating in group recreational programs. This one is bicycling.

So apparently the new secretary is considering authorizing VA medical center directors to support this particular activity.

I think this is very smart. I mean, we have got demonstrable outcomes in one area, and if VA directors locally are empowered with community volunteers and outside entities that will actually create these programs that have continuity but are embedded inside the VA.

Dr. KELLY. Yes. I would love it.

Mr. FORTENBERRY. It is not—as opposed to outside things, which are, of course, excellent and good, but bring embedded with the VA creates mechanisms of continuity that aren't always there.

Dr. KELLY. I couldn't agree more. You know, at the Warrior Games—and I was at Invictus this past year when it came to America—the physical activity and all of the equine groups, the Team Rubicon, the Red White and Blue, all of these groups, many of which have the physical component, I agree.

These are young men and women who are at the height of their athleticism. There is a reason why they still enjoy doing those activities when they come home.

And at the same time, what we often—again, anecdotally—talk to veterans about is the—and what a lot of civilians don't understand when they say they miss being in the military at a time when we are at war—is they miss the sense of belonging and belonging to a group that has purpose.

So those kinds of programs serve all of those, and we are very much in favor of them.

Mr. FORTENBERRY. Great. Thank you for your testimony.

Dr. KELLY. Thank you.

Mr. DENT [presiding]. Thank you, Dr. Kelly.

And at this time I would like to invite our final witness to the desk. It is Mr. Fred Sganga.

Fred, we appreciate your being here with us today, and I know you are a legislative officer at the National Association of State Veterans Homes. We appreciate your participation this morning

and we look forward to receiving your testimony. You are recognized for 5 minutes.

WEDNESDAY, MARCH 29, 2017.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

WITNESS

FRED SGANGA, LEGISLATIVE OFFICER

Mr. SGANGA. Thank you, Chairman Dent, Ranking Member Wasserman Schultz, members of the subcommittee. On behalf of the National State of Veterans Homes, thank you for the opportunity to provide testimony recommending $300 million for the Grants for State Extended Care Facilities program, commonly referred to as the State Home Construction Grant program, for fiscal year 2018.

As you know, for more than 125 years state homes have been in partnership with the Federal Government to provide long-term care services to honorably discharged veterans. There are currently 153 state veterans homes located in all 50 States and the Commonwealth of Puerto Rico.

The National Association of State Veterans Homes, which represents the homes, was established in 1952 to promote strong federal policies and share experience and knowledge among state home licensed nursing home administrators to allow us to care for our Nation's heroes with the dignity and the respect they deserve.

With over 30,000 beds, the State Veterans Home program is the largest provider of long-term care for our Nation's veterans, offering skilled nursing care, domiciliary care, and adult day health care. The Department of Veterans Affairs provides state homes with per diem payments for these purposes, which covers about one-third of the daily cost of care to these veterans.

VA also provides construction grants to build, renovate, and maintain the state veterans homes, with the States required to provide at least 35 percent of the cost for such projects in a matching fund program. The State Veterans Home program allows the VA to leverage federal resources to expand long-term services and support for veterans through partnerships with all 50 States.

Federal State Home Construction Grants are awarded based upon when a grant is received, where it falls among the statutory priority groups, and when state matching funds are certified as available. Projects that have been certified state matching funds are included in the VA's priority group one projects list, which includes critical life and safety projects as well as the new construction of state homes in states that will have a great need, as defined in the statute.

Grant requests that do not yet have state matching funds secured are placed in VA priority group two through eight on a list according to when they are submitted and according to their specific priority status.

Over the past several years VA has requested, and Congress has provided, between approximately $85 million and $90 million annually, which was barely enough to keep up with the new grant re-

quests from States and failed to make any significant headway with the existing backlog of priority one projects awaiting federal funding.

The most recent VA State Home Construction Grants priority list for fiscal year 2017, released in January, includes 99 requests; 57 are in priority group one, with a total federal cost share of approximately $639 million, an increase of $89 million to the backlog compared to fiscal year 2016.

There are also additional 42 grant requests among priority two groups through eight. Once those projects have been certified with state matching funding, they will, too, move to priority list one.

Overall, there are more than $1 billion of State Home Construction Grant requests that have been submitted to the VA.

With just $90 million for fiscal year 2017, VA will only be able to provide funding for the first 10 projects on the list, leaving 47 priority one projects awaiting a future year's funding.

For each of the past three fiscal years—fiscal year 2015 through fiscal year 2017—NASVH has recommended to Congress—to the VA and Congress that $200 million be allocated for the State Home Construction Grant program, a sum that was also recommended by the Independent Budget organizations.

For fiscal year 2018 NASVH recommends that $300 million be provided to the State Home Construction Grant program, which would provide sufficient funding to cover approximately half of the pending priority one projects. The I.B. also supports the recommendation of $300 million for fiscal year 2018 funding.

At this time it is not clear what level of funding the administration will request for fiscal year 2018. However, if the same inadequate amount of $90 million were to be appropriated for fiscal year 2018 it would support just the next seven priority one projects.

Given the recent trends of state matching funding, it is likely that this will result in little or no net decrease in the existing backlog of $639 million priority one projects. Among these projects that would not be funded at that level are two in Pennsylvania, two in Florida, two in California, and two in Ohio. All of those and 17 others, however, would receive funding next year if the $300 million were appropriated for fiscal year 2018.

As the veteran population continues to age and federal budgets continue to get tighter, there is no better investment of federal long-term care dollars than the State Home program, and we urge the subcommittee to significantly increase the funding for next year.

Mr. Chairman, I would also like to bring to the subcommittee's attention another issue that is beginning to have a significant impact on the level of funding required to sustain the state veterans home system: the VA's new Community Living Center, or CLC, design and construction guidelines. These new guidelines call for the state homes to use what is called the small house design when constructing new or renovating existing homes.

The small house design model is based on housing veterans in small group homes, or pods, each with their own kitchen, cleaning, and other basic facilities, along with separately assigned staff for

each small group home. The homes are physically connected through common areas for social, medical, and other purposes.

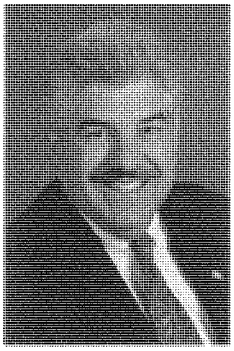
However, compared to the economies of scale that are achieved in traditional state veterans homes, the small house design has proven to be between 30 to 40 percent more expensive both to construct and to operate, imposing new financial burdens on the States. While some States have favored the small house design, others have found that many of the veterans prefer more traditional, larger state home model.

NASVH is recommending that the VA modify the Community Living Center design and construction guidelines to allow States sufficient flexibility in using the small house design so they can better meet the different needs of their respective veteran populations in a financially responsible manner.

Without such flexibility, Congress will need to significantly increase the level of funding for State Home Construction Grants to make up for the increased per capita costs as well as per diem rates to cover the higher operating costs.

Mr. Chairman, that concludes my testimony. Thank you for the opportunity to be here today before the subcommittee, and I would like to answer any questions you might have.

[The information follows:]



FRED S. SGANGA, MPH, FACHE, LNHA

Fred S. Sganga was chosen to serve as the Legislative Officer of the National Association of State Veterans Homes (NASVH), an all-volunteer organization of State Veteran Home administrators and senior staff.

Mr. Sganga is the Executive Director of the Long Island State Veterans Home at Stony Brook University, a 350-bed Skilled Nursing Facility serving honorably discharged veterans and their families. Board certified in Health Care Management and a Licensed Nursing Home Administrator, Mr. Sganga has worked in a variety of senior level healthcare positions in academic medical centers, community hospitals, long-term care facilities and physician practice management. Mr. Sganga earned his Bachelor of Science Degree in Community Health from Hunter College and his Masters of Public Health from Columbia University.

Mr. Sganga serves as an adjunct professor in the Graduate Healthcare Administration Programs at Stony Brook University and Hofstra University. He lectures extensively on the topics of Healthcare Leadership and Long-Term Care Management.

Mr. Sganga has also served as President of this organization in 2011-2012. In his current role as Legislative Officer, Mr. Sganga advocates on behalf on the 153 State Veterans Homes in all 50 States and the Commonwealth of Puerto Rico. The State Veterans Home program consists of 30,000 beds and is the largest provider of long term care to our nation's veterans.

He is also a Board Member of the National Council of Certified Dementia Practitioners. In addition, Mr. Sganga has served as Regent for the American College of Healthcare Executives representing the Greater New York area and is a member the Association's faculty. Mr. Sganga has received numerous awards during his career including the 2000 Award of Distinction from the Metropolitan Health Administration Association and the 2004 Community Recognition Award from the Veterans Administration for his commitment and dedication to our nation's veterans. In 2008, he received the MHA Program Professor of the Year from Hofstra University.

Mr. Sganga resides on Long Island with his wife Marianne, and they have two daughters; Danielle, a pediatrician at Stanford University, and Nicole, a journalist at CBS News.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

"Caring for America's Heroes"

TESTIMONY OF

FRED S. SGANGA, LEGISLATIVE OFFICER

NATIONAL ASSOCIATION OF STATE VETERANS HOMES (NASVH)

HOUSE MILITARY CONSTRUCTION, VETERANS AFFAIRS AND RELATED AGENCIES

APPROPRIATIONS SUBCOMMITTEE

MARCH 29, 2017

Chairman Dent, Ranking Member Wasserman Schultz and Members of the Subcommittee, on behalf of the National Association of State Veterans Homes (NASVH), thank you for the opportunity to offer testimony recommending $300 million for the Grants for State Extended Care Facilities program, commonly referred to as the State Home construction grant program for FY 2018.

As you know, for more than 125 years State Homes have been in a partnership with the federal government to provide long term care services to bonorably discharged veterans. There are currently 153 State Veterans Homes located in all 50 states and the Commonwealth of Puerto Rico. The National Association of State Veterans Homes (NASVH), which represents the Homes, was established in 1952 to promote strong federal policies and share experience and

knowledge among State Home administrators to allow us to care for our nation's heroes with the dignity and respect they deserve.

With over 30,000 beds, the State Veterans Home program is the largest provider of long term care for our nation's veterans, offering skilled nursing care, domiciliary care and adult day health care. The Department of Veterans Affairs (VA) provides State Homes with per diem payments for these purposes, which covers about one third of the daily cost of care. VA also provides construction grants to build, renovate and maintain the Homes, with States required to provide at least 35 percent of the cost for such projects in matching funds. The State Veterans Homes program allows VA to leverage federal resources to expand long term services and supports for veterans through partnership with the States.

Federal State Home Construction Grants are awarded based on when a grant request is received, where it falls among the statutory priority groups, and when State matching funds are certified available. Projects that have certified State matching funds are included in VA's Priority Group 1 projects list, which include critical life and safety projects, as well as new construction of State Homes in States that have a "great need" as defined in statute. Grant requests that do not yet have State matching funding secured are placed in VA's Priority Groups 2 through 8 list, according to when they are submitted and their specific priority status.

Over the past several years, VA has requested, and Congress has provided, between $85-$90 million annually, which was barely enough to keep up with new grant requests from States, and failed to make any headway with the existing backlog of Priority 1 projects awaiting federal

funding. The most recent VA State Home Construction Grants Priority List for FY 2017 released in January includes 99 grant requests; 57 are in Priority Group 1, with a total federal cost share of approximately $639 million, an increase of $89 million to the backlog compared to FY 2016. There are also an additional 42 grant requests among Priority Groups 2 through 8; once those projects have certified State matching funding, they will move to the Priority 1 list. Overall, there are more than $1 billion of State Home construction grant requests that have been submitted to VA.

With just $90 million for FY 2017, VA will only be able to provide funding for the first 10 projects on the list, leaving 47 Priority 1 projects awaiting future years funding. For each of the past three fiscal years (FY 2015-2017), NASVH has recommended to VA and Congress that $200 million be allocated for the State Home construction grant program, a sum that was also recommended by The Independent Budget (IB) organizations. For FY 2018, NASVH recommends that $300 million be provided for the State Home construction grant program, which would provide sufficient funding to cover approximately half of the pending Priority 1 projects. The IB also supports the recommendation of $300 million for FY 2018 funding.

At this time it is not clear what level of funding the Administration will request for FY 2018. However, if the same inadequate amount of $90 million were to be appropriated for FY 2018, it would support just the next seven pending Priority 1 projects. Given the recent trend of States matching funding, it is likely that would result in little or no net decrease in the existing backlog of $639 million for Priority 1 projects. Among those projects that would not be funded at that level are two in Pennsylvania, two in Florida, two in California and two in Ohio. All of those,

and 17 others, however, would receive funding next year if $300 million were appropriated for FY 2018.

As the veteran population continues to age, and federal budgets continue to get tighter, there is no better investment of federal long term care dollars than the State Home program and we urge this Subcommittee to significantly increase that funding next year.

New Design and Construction Guidelines for State Veterans Homes

Mr. Chairman, I'd also like to bring to the Subcommittee's attention another issue that is beginning to have a significant impact on the level of funding required to sustain the State Veterans Homes system: VA's new Community Living Center (CLC) design and construction guidelines. These new guidelines call for State Homes to use what is called the "small house design" when constructing new, or renovating existing homes. The small house design model is based on housing veterans in small group homes, each with their own kitchen, cleaning and other basic facilities, along with separately assigned staff for each small group home. The homes are physically connected through common areas for social, medical and other purposes. However, compared to the economies of scale that are achieved in traditional State Homes, small house design has proven to be between 30% to 40% more expensive for both constructing and operating new homes, imposing new financial burdens on States. While some States have favored the small house design, others have found that many of their veterans prefer the more traditional larger State Home model.

NASVH recommends that VA modify the Community Living Center (CLC) design and construction guidelines to allow States sufficient flexibility in using the small house design so they can better meet the different needs of their respective veteran populations in a financially responsible manner. Without such flexibility, Congress will need to significantly increase the level of funding for State Home construction grants to make up for the increased per capita costs, as well as per diem rates to cover the higher operating costs.

Mr. Chairman, that concludes my testimony. Thank you for the opportunity to appear before the Subcommittee. I would be happy to answer any questions you or other Members may have.

Mr. DENT. Thank you, Mr. Sganga, for your comments.

I also appreciate the work your folks are doing in our State, with six state veterans homes.

MISMATCH BETWEEN LOCATION OF VETERANS AND STATE HOMES

Mr. SGANGA. Thank you.

Mr. DENT. Just one question: Given that veterans as a group, are moving away from many of the areas in the Northeast and Midwest where state veterans homes are located, would it be better to contract out for long-term care rather than to continue to build or repair facilities in areas with declining veteran populations?

Mr. SGANGA. In my experience as a licensed nursing home administrator for over a 30-year period I do find, Mr. Chairman, that you will have Northeastern retirees that will go to other parts of the country for retirement, but I will tell you a significant amount of those veterans and their spouses return back to their original place of residence in order to receive long-term care services.

Mr. DENT. Are you saying my constituents are heading down to Ms. Wasserman Schultz's district? Is that what you are telling me?

Mr. SGANGA. Yes.

But they come back to die back in Pennsylvania. I mean, that is what happens.

Mr. DENT. On that point, there are statistics showing that if you are born in Pennsylvania you are likely to die in Pennsylvania.

Mr. SGANGA. Right. I have seen that. And spend 20 years in Florida.

Mr. DENT. People in Pennsylvania do like to spend time in Florida. Maybe not 20 years, though.

Mr. SGANGA. But I think that answers the question. The whole notion of long-term care, the trend that we are seeing is a lot more of our veterans are coming to homes much older.

Typically in my home—I am the executive director of the Long Island State Veterans Home in Stony Brook, New York—it is not unusual for a World War II veteran to be entering in their early 90s to the home.

Mr. DENT. Thank you.

Ms. Wasserman Schultz.

Ms. WASSERMAN SCHULTZ. Well, from a Long Island girl to a Long Island boy——

Mr. SGANGA. There you go.

Actually, I was born in Queens.

Ms. WASSERMAN SCHULTZ. Me too—Forest Hills. Long Island, Jewish, just like most of my constituents.

Which is why, Mr. Chairman, I always say that you should care about two people who represent you, particularly when I am up north: the person who represents you now—say, Mr. Dent—and me, because I am going to represent you when you retire and move to my district in about 20 years.

ALTERNATIVE TO LONG TERM FACILITIES

That having been said, Mr. Sganga, I do share the interest of the chairman in answering the question, particularly because people always prefer to age in place if they can, that not only should we explore long-term care options in other places, but—besides just

the Northeast, where I guess more of the homes are located and being constructed. I mean, we do have state nursing homes in Florida, and hopefully we will continue to build more of them because there is a real shortage of beds.

But I would think that your organization would be interested in trying to make sure that we could provide services to veterans where they would like to age, not necessarily in a particular home or facility. So have you ever explored broadening your mission?

Mr. SGANGA. That is a great question. Actually, three of our homes—Stony Brook, New York; Hilo, Hawaii; and Minneapolis, Minnesota—provide medical model adult day health care services, so that is one way that we do that. We would like to expand that.

I would like the subcommittee to know that we have been waiting 8 years for the VA to have the adult day health care regulations revised. We think as an association this is a disgrace, in terms of the time that it is taking to revise those regulations.

We have about 16 to 20 States who are on standby now to provide medical model adult day home care—health care to veterans and their spouses and widows, as well as gold-star parents, but they are not moving forward until they see publication of those regulations.

Ms. WASSERMAN SCHULTZ. Eight years?

Mr. SGANGA. That is correct.

Ms. WASSERMAN SCHULTZ. It has taken 8 years for them to——

Mr. SGANGA. We don't have them yet, so——

Ms. WASSERMAN SCHULTZ. Why?

Mr. SGANGA. You will have to ask the VA.

Ms. WASSERMAN SCHULTZ. I will.

Mr. SGANGA. Okay. Thank you.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

Mr. DENT. Thank you, Ms. Wasserman Schultz.

I would like to recognize at this time the vice chairman of the subcommittee, Mr. Fortenberry.

Mr. FORTENBERRY. Thank you, sir, for appearing.

The veterans homes approximate to my district seem to be very happy places, to be honest with you.

Mr. SGANGA. That is correct.

VETERANS ORAL HISTORY PROJECT

Mr. FORTENBERRY. And the decided focus on the particular needs of the veteran but also the celebration of the lives of the veteran and an inclusion of families is a dynamic that I have witnessed that, frankly, I am very proud of, so thank you for your work.

One thing I would encourage you to do if you haven't already is there is a veterans history project coordinated through the Library of Congress, and we have made several offerings to veterans in our community—one at the vets home, which we actually facilitate the recording of the veterans' stories. And I remember one time a woman veteran, World War II veteran, told me, "Well, I didn't really have anything great to say about my service in the war. I mean, I joined after my five brothers joined."

I said, "What? There were six of you from one family?" "Oh, yes."

And I said, "Well, tell me"—in other words, this person, her own greatness, her own willingness to sacrifice, her own understanding

of what she did as simply dutiful and not extraordinary was a reason itself that it was so extraordinary and a reason to capture that memory.

So one of the things I just wanted to suggest to you is if it is not already a part of the culture that for veterans who are in your homes to get those stories recorded and be permanently here in our nation's archives. And I think it has a lot of meaning to them, particularly the older veterans for whom, as you are quite aware, there wasn't a culture in which people talked about their service or what they saw.

In fact, we did one of these recordings with a veteran—a World War II veteran; I believe he was about 90 at the time—who, through that interview, we actually were able to determine that there was post-traumatic stress disorder that had never been caught, diagnosed. And now he is receiving some treatment at a very old age.

Nonetheless, it is a great way to continue this celebration of vet services, and you, as a platform, a home for so many veterans, I think the more we can do to capture those stories, it is not only beneficial for the Nation but it is a great service to the individual.

Mr. SGANGA. Mr. Vice Chairman, thank you for recognizing the special culture that does exist at any state veterans home.

I can tell you that a typical nursing home in the United States of America is probably 75 percent women, 25 percent men. In Stony Brook where I am, and a lot of my colleagues, we are about 90 percent men and 10 percent women. So that does create a little bit of a different atmosphere. If we were to return in 50 years I am sure it would be a lot different.

But as a licensed nursing home administrator in a state veterans home, we are constantly looking out for the needs of both men and women whose service provided the freedoms we enjoy today.

And I want to let you know that, indeed, a good portion of our state veterans home program participates in the Veterans Oral History Project.

Mr. FORTENBERRY. Great. Good. Thank you.

Thank you, Mr. Chair.

Mr. DENT. Mr. Bishop.

Mr. BISHOP. Thank you, Mr. Chairman.

Mr. Sganga, thank you so much for your service, and thank you for supporting the grants for state extended care facilities programs.

All of our States have stressed budgets and, of course, that program would certainly supplement what the States are able to do, and so I thank you for that.

I don't have any questions for you.

I yield back, Mr. Chairman.

Mr. DENT. Thank you, Mr. Bishop.

And before we adjourn I just want to make a few comments.

First, the Capitol Police advise us that Independence Avenue is still blocked due to an ongoing investigation or an incident, actually. For your safety we would ask that our witnesses and guests use the first-floor exit for the Rayburn Building, which is open to South Capitol Street. You will be directed to walk east away from the mall. So we just wanted you to be aware of that.

I would also like to mention to the group that today's hearing is being webcast. It will be available on the committee's Web site, Facebook page, and YouTube link, so I wanted you to be aware of that, as well.

And finally, I just wanted to say thanks to all of our witnesses today and to your organizations for the very important work that you are doing on behalf of our Nation's veterans. Your advocacy and your dedication and commitment are deeply appreciated, and we just want to say thank you for that.

So with that, this hearing will be adjourned. Our next hearing is on Wednesday, May 3, with the secretary of the VA.

Thank you all. Have a good day.

WEDNESDAY, NOVEMBER 15, 2017.

VETERANS AFFAIRS ELECTRONIC HEALTH RECORD

WITNESSES

HON. DAVID J. SHULKIN, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

JOHN H. WINDOM, PROGRAM EXECUTIVE, ELECTRONIC HEALTH RECORD MODERNIZATION

SCOTT R. BLACKBURN, EXECUTIVE IN CHARGE, OFFICE OF INFORMATION AND TECHNOLOGY

OPENING STATEMENT CHAIRMAN DENT

Mr. DENT. Good morning. Well, thank you all for coming out.

We have convened this hearing with the Secretary of the VA to discuss a very important and expensive issue that was first presented to us last week—VA's plan to sign a contract with Cerner Corporation for an electronic health record. The record will use the same platform the DOD has purchased from Cerner for its health record.

Since this need developed after the fiscal year 2018 budget was submitted and before we received the fiscal year 2019 budget, the VA proposes to begin funding it through a reprogramming request.

We understand that you have not completed negotiations with Cerner, so there are some total cost issues you are not able to discuss in open session out of concern about generating bid protests. We intend to pursue those issues in a closed session that will follow this one. However, we are confident we can discuss the major elements of the contract in public.

For veteran members of the committee like Chairman Frelinghuysen and Ranking Member Lowey, the creation of a electronic health record has become a tired refrain. They have been hearing about it since the mid-1990s. VA Secretaries have come and gone, promising that their records were achieving interoperability or that they were developing the same record as DOD or that they had decided to have two different systems that would talk to each other.

Now the pendulum has swung back once again to creating one record to be used by both departments, the position this committee has argued for from the start. The number of years and dollars that have been wasted reaching this point is extremely troubling.

Mr. Secretary, we know that we cannot lay this past history at your feet, but you will forgive us for being a little skeptical that, at this late date, the VA has now found the answer to its electronic health record conundrum. We know you are anxious to sign the contract with Cerner, but the committee will need more information before it is comfortable with approving this first step down a long and expensive road.

Before we ask you to give a statement, I would like to inquire if Ranking Member Wasserman Schultz has any comments.

Ms. WASSERMAN SCHULTZ. I do. Thank you, Mr. Chairman.

Mr. DENT. You are recognized.

OPENING STATEMENT RANKING MEMBER WASSERMAN SCHULTZ

Ms. WASSERMAN SCHULTZ. And welcome, Secretary Shulkin.

Thank you, Mr. Chairman.

And we do appreciate you being here on fairly short notice so that we can discuss the VA's efforts to modernize its electronic health records platform.

But I really think, especially because we have some new members, including a relatively new member, myself, that we walk everyone through the EHR timeline thus far and the unbelievably lengthy process that this has been, even for government.

Mr. Chairman, as you know, in 1998, during the Clinton administration, a Presidential review directive acknowledged that DOD and VA systems were not compatible and that actions should be taken to identify data exchange systems.

In 2003, President Bush established a task force to improve healthcare delivery for veterans, and it recommended that the Departments develop an interoperable record.

In 2007, the President's Commission on Care for America's Returning Wounded Warriors also supported interoperability, the genuine ability of these two systems to seamlessly exchange and make use of the other's information.

Then, in 2009, President Obama announced that DOD and VA would be working together to build a seamless system of integration.

Fast-forward to 2011, when VA Secretary Shinseki and DOD Secretary Gates announced plans to create a single electronic record.

However, just 2 years later, in 2013, the two Departments announced that they would no longer create a single, common health record and, instead, solely focus on interoperability. The VA chose to modernize its existing VistA health record in-house, while DOD announced it would contract a commercially produced health record.

In response to that problematic announcement, the House-reported fiscal year 2014 MILCON–VA bill directed the VA and DOD to develop a single electronic health record. I stress: directed the VA and DOD to develop a single electronic health record.

Unfortunately, the committee was forced to remove that requirement after discussions with the House Armed Services Committee. The final appropriations language permitted either a single system or two interoperable records.

After that battle was lost, DOD went on to award a $9 billion contract to Cerner to develop the DOD health record, while, at the same time, VA efforts to modernize VistA underwent further review.

Mr. Chairman, I believe we can agree this would not have led to genuine interoperability, and the patchwork of the Joint Legacy Viewer has left much to be desired.

Finally, earlier this summer, the VA announced its intention to award a single-source contract to Cerner to provide VA the same electronic health record DOD is developing, as well as follow the same rollout cycle being operated by DOD.

So, Mr. Chairman, this issue could have and should have been resolved years ago. It is no wonder that our constituents get incredibly frustrated with the insanity of the bureaucracy of many Federal agencies, and this is a textbook case. When I think about the time and resources that have been wasted over the years on this endeavor, it is easy to see why members have such strong feelings and such frustration concerning this issue.

And I share the chairman's recognition that it is certainly not at your feet, but it is at your predecessors' feet and people who have been working on this for probably all of those years.

And while I am pleased that the VA is moving in the direction of creating an integrated health record system, finally, with DOD, like we thought should happen years ago, I was not thrilled about getting a $782 million reprogramming at the end of October that needed to be acted on by November with no real details.

I am also concerned about how this new system will work with the private-sector providers. And that is a question that I hope you are going to address in your testimony. If not, I will ask you. With veterans taking advantage of community care in significant numbers, we need to ensure that the new EHR system will be able to seamlessly exchange data between the private sector and the VA.

Years down the road, I hope to not be at a hearing where we are discussing our frustration over the less-than-complete interoperability and ability to seamlessly move electronic health records from DOD and military service all the way through, including to the private sector. So I look forward to the opportunity to hear your thoughts and share my concerns.

And I yield back.

Mr. DENT. I thank the ranking member.

At this time, I would like to recognize the chairman of the full committee, Mr. Frelinghuysen.

OPENING STATEMENT OF FULL COMMITTEE CHAIRMAN FRELINGHUYSEN

The CHAIRMAN. Great. I want to thank you, Chairman Dent and Ranking Member Wasserman Schultz, for scheduling this hearing.

And I want to thank everybody for being here today.

Dr. Shulkin, it is good to be with you and your colleagues.

We are here today because of your reprogramming request for additional resources for your electronic health records project. As all of us are painfully aware, the VA and DOD electronic health record compatibility, as has been mentioned, has been an issue for over 20 years.

In fact, 4 years ago, your predecessor, Rick Shinseki, and Department of Defense Secretary Chuck Hagel met with Mrs. Lowey and with my predecessor, Hal Rogers, and made a fairly public commitment to get the damn job done. And some sort of a solution was supposed to be reached within a year. It was never done. DOD went one way; VA went another way.

Despite those decisions, Congress has supported in a bipartisan way, the joint effort by providing billions of dollars over the years for these different projects. So when the committee was asked on short notice to approve a reprogramming to get yet another proposed project started and one that would require many billions of dollars over a long period of time, it was clear we needed some answers.

Today, we need answers: True cost? What can be salvaged from the old system? And when it is all said and done, will the systems be seamless? And will this investment take away from dollars needed to replace existing old IT systems in the many veterans hospitals we have around the country? We have dozens of them, old systems.

And will it take away from meeting the challenges of the new Choice Program and, may I say, a constant irritant to me, the embarrassing backlog of cases? I mean, some of these men and women are in their eighties and they are waiting for some sort of adjudication of their cases. Totally inexcusable.

I know the focus here is on electronic medical records. Two priorities for the entire Appropriations Committee, not just this subcommittee, which Chairman Dent runs well, is that we ensure that we are providing the best medical care for our veterans and that we are setting out a fiscally responsible course to meet their needs. All of us want to hear in detail and for the record how that is going to be done.

Thank you, Mr. Chairman.

Mr. DENT. Thank you, Chairman Frelinghuysen.

At this point, I would like to ask the Secretary to introduce his panel and then proceed with your testimony.

Thank you, Mr. Chairman.

Thank you, Mr. Secretary. You are recognized.

SECRETARY SHULKIN OPENING STATEMENT

Secretary SHULKIN. Well, Chairman Frelinghuysen, Chairman Dent, Ranking Member Wasserman Schultz, and all the members of the committee, thank you for being here. And our intent is to be candid and answer all your questions this morning.

I have with me, to the right, Scott Blackburn, who is the executive in charge of information and technology, and, to my left, John Windom, the executive for the electronic health record modernization.

And, as you know, VA and DOD have been working on trying to get interoperable electronic medical records for quite some time. I was only able to trace the history for 17 years, but I am going to defer to the ranking member, who I think did a much better historical record of this than I did, so we are going to use her timeline. It has been quite a while.

And, Chairman Dent, I think skepticism is appropriate. I don't know any other way to interpret history than to say that this has taken way too long, and there have been many false starts along the way. So I am right with you.

I think that there is enough blame on both sides here, with DOD and VA. So I am not going to spend a lot of time on the history. I will tell you, right now—because that is really my best chance to

sort of assess the situation—I have never seen better cooperation between DOD and VA. And I have to give a lot of credit to Secretary Mattis and Deputy Secretary Shanahan for leading this and saying we are going to get this done. So I think everyone is in agreement, this has taken too long.

Even besides the fact that we don't have interoperable systems, VistA by itself is not a system. It is 130 different instances of an electronic medical record. That is insane, but that is the system that we have today.

So we could continue down the same path that we are right now, without DOD and VA being interoperable, with VA having 130 different electronic medical records. But we could, alternatively, go for a commercial, off-the-shelf system that is going to provide a single system with DOD and give veterans seamless care and this integration with community providers that the ranking member mentioned.

From my perspective, maintaining the status quo is just not acceptable. The health and safety of our veterans is our Nation's highest priorities—among our highest priorities. On that, I know that everyone here agrees in a bipartisan way.

Critical to meeting that priority is a complete and accurate veterans health record in a single common EHR system. Adopting the same EHR as DOD will vastly improve VA services and significantly enhance the coordination of care for veterans, not only at VA facilities but also at the Department of Defense and with community providers.

Continuing to pursue VistA EHR interoperability would fall short in providing veterans the quality healthcare that we can give while throwing good money after bad. So, on June 5th of this year, after carefully looking at the data, I announced my decision to adopt the same electronic health record as the Department of Defense.

And I am convinced adopting the same EHR system that DOD uses is the best solution. It will allow VA to keep pace with health information technology and cybersecurity improvements that VistA simply cannot achieve. Veterans' health information will reside in a single common system, providing seamless care between the Department of Defense and VA. We will be able to share veterans' health information with our community partners. And for those transitioning servicemembers, veterans' medical records will be at VA on day one.

In working hand-in-hand with DOD on the same system, we are going to gain the advantage of their lessons learned, while making sure we fully achieve interoperability objectives. We are also committed to working with other EHR vendors besides Cerner and leading technology companies to create interoperability with our academic and community partners within the communities where our veterans live.

This is the best decision for veterans in the short term and long term, and it is the best decision for taxpayers. Upgrading and maintaining VistA to industry standards will cost approximately $19 billion over 10 years—that is an independent study that was done by Grant Thornton—and we will still not achieve the necessary VA–DOD interoperability that the new EHR system that we are proposing will provide.

The new EHR system over 10 years will be billions less than the $19 billion required for our current system. We are going to discuss the specifics in closed session, as you suggested, Mr. Chairman.

And by moving from over 130 instances of VistA to a single instance of the new EHR, we will save billions more in efficiencies and quality improvements. I look forward to discussing those details, as well, in the closed session. But what I can say here is that we are achieving substantial discounts, choosing the same system as DOD and aligning our system deployment with theirs.

Mr. Chairman, we want to work with Congress to find a common solution to funding this EHR modernization plan in fiscal year 2018. We prefer to fund the plan as part of the enacted 2018 appropriations bill, as I think you do too; however, we have to do this quickly.

We have achieved substantial discounts by aligning our EHR deployment and implementation with the Department of Defense's.

Absent an appropriation bill by the end of the calendar year funding the plan, we ask Congress to consider approving our transfer request so we can promptly award the contract. This contingency enables VA to avoid cost increases and allows us to move forward with IT infrastructure modifications and expanding our program management office to provide the necessary oversight and manage implementation.

I do ask you consider establishing a new, separate appropriation account for EHR modernization costs. That way, we can capture everything in one place for the sake of full transparency and accountability, from our initial operating capacity to full deployment and other important decision points along the way.

Mr. Chairman, the electronic health record modernization plan is right for veterans' healthcare, and it is right for taxpayers. It will significantly improve VA services and enhance the coordination of care at VA, DOD, and in the community.

Thank you for the partnership in helping us improve how we care for our Nation's veterans.

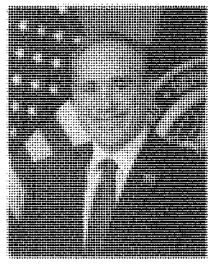
[The information follows:]

Department of Veterans Affairs

Senior Executive Biography

David J. Shulkin, M.D.

Secretary of Veterans Affairs



The Honorable David J. Shulkin was nominated by President Trump to serve as the ninth Secretary of Veterans Affairs (VA) and was confirmed by the United States Senate on February 13, 2017.

Prior to his confirmation as Secretary, Dr. Shulkin served as VA's Under Secretary for Health for 18 months, leading the Nation's largest integrated health care system, with over 1,700 sites of care serving nearly nine million Veterans.

Before he began his service with VA, Dr. Shulkin held numerous chief executive roles at Morristown Medical Center, and the Atlantic Health System Accountable Care Organization. He also served as President and CEO of Beth Israel Medical Center in New York City.

Dr. Shulkin has held numerous physician leadership roles including Chief Medical Officer of the University of Pennsylvania Health System, Temple University Hospital, and the Medical College of Pennsylvania Hospital. He has also held academic positions including Chairman of Medicine and Vice Dean at Drexel University School of Medicine. As an entrepreneur, Dr. Shulkin founded and served as Chairman and CEO of DoctorQuality, one of the first consumer-oriented sources of information on quality and safety in healthcare.

A board-certified internist, Dr. Shulkin is also a fellow of the American College of Physicians. He received his medical degree from the Medical College of Pennsylvania, and he completed his internship at Yale University School of Medicine and a residency and fellowship in General Medicine at the University of Pittsburgh Presbyterian Medical Center. He also received advanced training in outcomes research and economics as a Robert Wood Johnson Foundation Clinical Scholar at the University of Pennsylvania.

Dr. Shulkin has been named as one of the "50 Most Influential Physician Executives in the Country" by Modern Healthcare. He has also previously been named among the "One Hundred Most Influential People in American Healthcare." He has been married to his wife, Dr. Merle Bari, for 29 years. They are the parents of two grown children.

Updated February 2017

STATEMENT OF THE HONORABLE DAVID J. SHULKIN
SECRETARY OF VETERANS AFFAIRS

FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES
ELECTRONIC HEALTH RECORDS MODERNIZATION

November 15, 2017

Good morning, Chairman Frelinghuysen, Chairman Dent, Ranking Member Lowey, Ranking Member Wasserman Schultz, and Distinguished Members of the House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies. Thank you for the opportunity to testify today regarding VA's Electronic Health Record Modernization (EHRM) plan. I am accompanied today by Scott Blackburn, Executive in Charge of Information and Technology, and John H. Windom, Program Executive for Electronic Health Records Modernization. This statement will not discuss costs or other sensitive details due to the prohibition on the release of source selection and contractor bid or proposal information. I will be happy to discuss any details with you in the closed hearing.

The health and safety of our Veterans is one of our highest national priorities. On June 5, 2017, after carefully studying the data, I announced my decision to adopt the same electronic health record (EHR) system as the Department of Defense (DoD), which at its core is about improving VA services and significantly enhancing the coordination of care for Veterans who receive medical care not only from VA, but DoD and our community partners. Having a Veteran's complete and accurate health information in a single common EHR system is critical to that care, and to patient safety. This new EHR system will enable VA to keep pace with the improvements in health information technology and cyber security which the current system, VistA, is unable to do. In addition, the new EHR will support the critical need for VA to successfully and efficiently share patient data with DoD and community partners.

With Congress's urging, VA and DoD have been working together for over 17 years on EHR issues. While we have established some interoperability between VA and DoD for key aspects of the health record, we still do not have the ability to transmit information to seamlessly execute a shared plan of care for our Veteran patients. Without improved and consistently implemented national interoperability standards, VA and DoD will continue to face significant challenges in providing the highest quality of care for our Veterans.

For these reasons, I decided that VA would adopt the same EHR system as DoD. Adopting Cerner's EHR system, which I believe is in the Veterans' and the public's interest, will ultimately result in all patient data residing in one common system. It will enable seamless care between the Departments without the current manual and

electronic exchange and reconciliation of data between two separate systems that we still have to rely upon today. It will also result in better service to our Veterans because transitioning service members will have their medical records at VA on day one.

Replacing VistA is a Must

Continuing to maintain VistA is more costly in the long-run and will not meet full interoperability. To bring VistA up to where it needs to be, is our most expensive option. VA would have to spend $19 billion over ten years to upgrade and maintain VistA to industry standards, and this still would not provide all the needed upgrades and interoperability with DoD. In addition, VA currently has fewer programmers than it did when VistA was designed. VistA is, in many ways, like the car that we love and don't want to trade in, though it is now costing us way too much money to maintain.

The reality is that the VistA system itself represents 130 different evolutions of the VistA EHR, further complicating the goal of true interoperability. Continuing to pursue VistA EHR interoperability would fall short in providing Veterans the quality health care that we can while throwing good money after bad. Even if VA were to make the required upgrades to VistA, it still would not be able to deliver all the capabilities that the new Cerner EHR system will include, specifically a single common system to provide seamless care with DoD, and improved integrated interoperability with community providers via health information exchanges.

Funding Request

The EHRM cost will support the new EHR contract, necessary infrastructure improvements for VA to support the EHR system, and a Program Management Office (PMO) support contract to provide quality assurance (clinical/technical) IV&V testing, earned value, and other support necessary to oversee EHRM efforts. Additional details can be provided in closed session. Failing to adequately fund the initiative will increase total costs and implementation time.

Transfer Request to Fund FY 2018 Requirements

We want to work with Congress to find a solution that provides the needed funding for EHR modernization requirements in FY 2018. For FY 2018, the initial year of the contract, VA is proposing to fund the project entirely from within our existing resources. VA proposes to redirect a total of $782 million in FY 2018 to initiate the EHRM project - $92 million from the OI&T account and $690 from the Medical Care accounts. However, because there is a 10 percent transfer limitation into the IT account and funding restrictions under the Continuing Resolution, VA has requested to transfer $373.8 million at this time. This is the minimum level needed to allow VA to execute the contract for a new electronic health record system, begin IT infrastructure modifications, and expand VA's EHRM Program Management Office to manage implementation and oversight. Absent an appropriations bill by the end of the calendar year, the proposed

transfer and reprogramming is necessary to promptly award the contract and prevent cost increases due to contract delays.

The transfer amount will come from higher than anticipated unobligated balances in Medical Services, and a modest reduction to the Medical Support and Compliance (MS&C) account. The total transferred resources in FY 2018 represents less than one percent of the anticipated Medical Care resources available in FY 2018. EHRM will improve VA services and significantly enhance the coordination of care for Veterans who receive care not only from VA, but from DoD and the community.

Of the initial transfer amount of $373.8 million, $49.9 million will come from the Medical Support and Compliance account. This MS&C transfer will directly support the PMO activities for EHRM. The funding is available from FY 2017 unobligated balances due to reduced funding for VHA central office program offices, as the VACO hiring freeze and modernization efforts to de-layer VACO proceed.

The remaining funding for the initial transfer comes from Medical Services account budget for equipment. The transfer of Medical Services carryover reflects the postponement of some medical equipment refresh until the end of 2018 or early 2019. After the transfer is executed, VHA will have approximately $1.2 billion for equipment in FY 2018. VHA will prioritize equipment needs to ensure any urgent needs are met to provide care to our Veterans.

Failure to fully fund the $782 million in FY 2018 is not an option as it will escalate costs and reduce DoD coordination. VA would welcome FY 2018 appropriations being enacted before the end of the calendar year, and we acknowledge your concerns with the proposed offsets to internally fund EHR modernization in 2018. However, we do have to act quickly. We achieve substantial discounts by aligning our EHR deployment and implementation with DoD's. Absent an appropriations bill being enacted by the end of the calendar year that funds the EHR modernization plan, we will ask Congress to approve the transfer request so that we can promptly award the contract. That contingency avoids cost increases and allows us to move forward with the IT infrastructure modifications and expanding our Program Management Office to provide oversight and manage implementation.

Efficiencies as a Result of EHR Modernization

VA will find considerable savings/efficiencies across our existing systems. All VistA EHR elements will be replaced by our Cerner EHR modernization efforts. The Cerner solution and VistA EHR will be operating simultaneously for an extended period of time with the appropriate decommissioning plan of VistA to ensure no disruption of services to our Veterans during the transition of capabilities from VistA to our modernized EHR.

The VA Electronic Health Record Modernization (EHRM) Team is working hand-in-hand with their DoD counterparts to ensure that seamless care and information

exchange objectives are fully realized. Efforts include the exchange of lessons learned, alignment of EHRM deployment schedules to support early interoperability successes and the establishment of an interagency governance board to promote configuration management control and long-term adherence to interoperability objectives.

Oversight and Transparency

VA will provide full transparency in this project, including an Initial Operating Capability (IOC) milestone and other decision points prior to full deployment. We would also like to request establishment of a separate new appropriation account for EHRM costs. A separate account would allow all EHRM costs to be captured in one place, provide full transparency of and accountability for resources, and enhance EHRM implementation.

Conclusion

I ask for your continued steadfast support in approving our plans to move forward with the Cerner EHR contract award, and for your continued partnership in making bold changes to improve our ability to serve Veterans. I look forward to your questions.

Scott R. Blackburn

Mr. Blackburn was designated to serve as the Executive in Charge for the Office of Information and Technology on October 2, 2017 by VA Secretary David J Shulkin, M.D.

Mr. Blackburn was appointed Department of Veterans Affairs Interim Deputy Secretary on February 26, 2017.

Mr. Blackburn joined VA in November 2014, serving first as Senior Advisor to the Secretary on Transformation and, then, as Interim Executive Director of the MyVA Task Force.

That means he's helped conceive, design, launch, manage, and now, lead VA's ambitious journey to be a world-class service provider and the No. 1 customer-service agency in the Federal government.

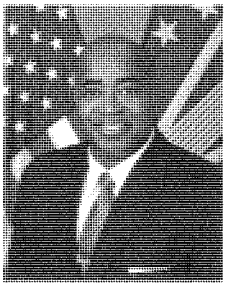
Prior to VA, Mr. Blackburn was a consultant at McKinsey & Company, where he helped transform cultures of large, often bureaucratic, Fortune 500 companies. He was named partner in 2011.

Mr. Blackburn hails from a family with a strong tradition of military service. All four of his siblings are Veterans, and he served in the Army from 1999 to 2003 as an Armor and Signals Corps officer. Mr. Blackburn's a Veteran of Operation Enduring Freedom and Operation Anaconda in Afghanistan.

Medically discharged after a non-combat-related back injury in Kuwait, Mr. Blackburn's a beneficiary of VA's Vocational Rehabilitation Program that facilitated a smooth transition from uniform to university. In 2005, Mr. Blackburn graduated from Harvard Business School

Born in Concord, Massachusetts, he's particularly proud that he was raised in the coastal town of Scituate, popularly known as the Irish Riviera.

John H. Windom Bio



John H. Windom is Director of the Electronic Health Records Modernization (EHRM) Program Executive Office (PEO), as a member of the Senior Executive Service (SES), where he directs the acquisition, integration, deployment and oversight of a state-of-the-market Electronic Health Record (EHR) in support of seamless care and health data movement objectives between VA and the Department of Defense (DoD). Establishing a single common EHR system between VA and DoD will be a key enabler to delivering seamless care to our Veterans and active duty service members alike. This project will take several years to complete and will include transitioning over 130 versions of VistA medical modules to the new EHR.

Prior to coming to VA, Mr. Windom held the rank of Captain in the United States Navy. He comes to VA with a wealth of knowledge regarding the DoD EHR as he was assigned to Program Executive Office Defense Healthcare Management Systems (PEO DHMS) [under the Office of the Undersecretary of Defense for Acquisition Technology & Logistics] as the Defense Healthcare Management Systems Modernization (DHMSM) Program Manager from October 2013 to December 2015; a multi-billion dollar Acquisition Category One (ACAT I), with a major program management designation, chartered to acquire, test, integrate and field/deploy (worldwide) a new EHR system. The EHR system was acquired to replace existing DoD legacy EHR systems in support of over 9.6 million military service members and other beneficiaries. Then CAPT Windom led the highly successful competitive acquisition and contract award (without protest) of the new commercial EHR system and related services. His program management and acquisition efforts saved DoD several billion dollars relative to previously budgeted and anticipated program life cycle cost estimates. The EHR solution acquired under DHMSM is now known as "MHS Genesis."

Mr. Windom's last position before retiring and coming to VA was as Manpower, Personnel, Training and Education (MPT&E) Transformation Program Manager under of the Office of the Chief of Naval Personnel (CNP) on special assignment from Assistant Secretary of Defense for Research Development and Acquisition (ASN RD&A). He was charged with developing and implementing an acquisition strategy to transform/transition the Navy's 55 legacy human resource (HR) management systems to a state of the market commercial HR solution/product.

In the years prior, he held positions as the Executive Director for Acquisition and Procurement for the Navy, Head Procuring Contracting Officer (PCO) for the Next Generation Enterprise Network (NGEN), Deputy Director for Operations Defense Contract Management Agency (DCMA) International Division,, Director of Financial and Business Operations for the DCMA International Division.).His final sea tour was as Assistant Supply Officer (ASUPPO) and Principal Assistant for Services (PA5) in USS HARRY S. TRUMAN (CVN 75). He also successfully completed department head tours as Supply Officer in USS DUBUQUE (LPD 8), USS JUNEAU (LPD 10) and USN5 MERCY (TAH 19). CAPT Windom also served as a division officer on the guided missile cruiser USS VALLEY FORGE (CG 50) and as a nuclear trained operator aboard USS ARKANSAS (CGN 41).

CAPT Windom has been awarded the Defense Superior Service Medal by the Secretary of Defense, and was awarded the Bronze Star Medal by the Multi-National Force Corps Commander for meritorious service in support of coalition forces in Iraq and Afghanistan, where he served as the Theater Contracting Officer. He has also been awarded the Legion of Merit, Defense Meritorious Service Medal, Meritorious Service Medal, Joint Service Commendation Medal, five Navy Commendation Medals, two Navy Achievement Medals and a number of other service, unit and campaign medals, awards and citations.

John Windom was a 1992 graduate of University of Memphis (B.S. in Electronics Engineering) and 2002 graduate of the Eli Broad School of Business at Michigan State University. He presently resides in Maryland (Washington, D.C. metropolitan area).

Mr. DENT. Thank you, Mr. Secretary.

Would you introduce your panel that's with you today, please?

Secretary SHULKIN. Yes. Mr. Scott Blackburn, the executive in charge of information and technology, and Captain John Windom, who is in charge of our EHR modernization.

Mr. DENT. Thank you.

At this time, let's go right to questions.

DESCRIPTION OF PROPOSED EHR SYSTEM

Mr. Secretary, could you please start by laying out for us the type of records system you are contracting for, what capabilities VA needs, the timeframe and geographic rollout you plan nationwide, and the impact it will have both financially and in terms of patient healthcare?

Secretary SHULKIN. Well, we have been working very hard to answer all those questions. And we do have a very specific timeline/project plan objectives. And in order to do this in the most succinct and accurate way, I am going to ask Captain Windom to respond to that.

Mr. WINDOM. Retired, sir.

Secretary SHULKIN. Okay.

Mr. WINDOM. I appreciate the opportunity, and thank you, Mr. Chairman.

Because we have a closed session forthcoming, I can speak in greater detail in a closed session. But, overall, we intend to award a 10-year contract. Within that 10 years, we anticipate deploying to the full enterprise the full breadth of the 1,600-plus facilities and community providers that support those respective facilities. We believe that within that 10-year timeframe that is very much achievable.

And following the signing of the D & F back on June 5 by Secretary Shulkin, we entered into immediate and direct negotiations with Cerner Corporation such that, as part of an alpha contracting process, we are able to communicate across the table to fully assess not only their concerns for deployment but to offer them full understanding of the environment that they are going to be deploying to. And, therefore, we are very comfortable with a plan that deploys across the enterprise in less than 10 years.

We intend to align our efforts to those of DOD today. I was fortunate enough to lead the program office for DOD that successfully acquired Cerner through a competitive acquisition. So very comfortable that I have seen both sides of the fence.

I am also very comfortable that we are leveraging the lessons learned that DOD has in their associated deployment challenges. But that alignment, that critical alignment early in the process allows us to move out more aggressively in our approach, to be more efficient in our approach, and, again, to maintain the requisite configuration management over both sides, DOD and VA, that will support seamless information exchange well into the future.

So hopefully I answered your question, but subject to your additional questions, I will pause.

ROLLING OUT SYSTEM GEOGRAPHICALLY

Mr. DENT. Yes. Mr. Windom, you said you were going to roll this out across the whole system. Geographically, in what areas are you going to start?

Mr. WINDOM. So, presently, DOD is in the Pacific Northwest. They just went live in Madigan Hospital, and they have gone live at three other facilities. So it is our intent to deploy also to the Pacific Northwest.

It is inherent economies of scale gained by labor efficiencies. I can't speak for Cerner Corporation, and I won't delve overly into the specifics of the negotiation, but there is clearly—by us deploying into the same geographical area, we will be able to leverage the resources that are already in that area. If we deployed east, clearly they would have to stand up a full-team that would have to, again, support our deployment on the opposite part of the country that DOD is in fact deploying.

So we believe and have seen as part of the negotiation process substantial efficiencies in that area and in that strategy.

Mr. DENT. Back to Secretary Shulkin, your reprogramming proposes to move funding in two ways, from medical services and medical support and compliance, to jump-start the program, with appropriated funding first assumed for fiscal year 2019.

The first wave of transfers is $324 million from medical services and $50 million from headquarters staff hiring. We understand the hiring freeze has generated the $50 million, but the $324 million from medical services will be a hard sell to outside organizations, some of whom are probably represented here today.

I know you say it is for medical equipment purchases that can be recouped at the end of the year, but your fiscal year 2018 budget already starts out with a $245 million cut to medical equipment. So merely getting back to the original cut level isn't particularly reassuring.

How are you going to characterize this publicly?

Secretary SHULKIN. Well, first of all, we would prefer to take the strategy that I believe that you would also support, which is not to do this transfer but to get the 2018 appropriations done before the end of the calendar year.

We are in somewhat of a time crunch, in that, in order for us to achieve the efficiencies that Mr. Windom just talked about, we do need to align closely with the DOD implementation. And so we are trying to do the best thing for taxpayers here.

What we have proposed is an alternative if we are not able to get the 2018 appropriations bill done, where we would use some money that was from carryover from 2017 as a stopgap to be able to start this project, and then we would refund it, we would replenish that money so we do not believe that this will end up delaying or hurting veterans' healthcare. But it is not our preferred strategy.

Mr. DENT. Thank you.

I have additional questions, but we have a lot of members here, so I want to go right to their questions.

Ranking Member Wasserman Schultz is recognized for 5 minutes.

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman.

CATCHING UP TO DOD EHR DEPLOYMENT

The frustrating thing here is that the VA—and I say VA, not you—but the VA's foot-dragging and missteps have become our emergency.

Because DOD has jumped ahead and gone forward with what we should have been doing in parallel. You know, as an appropriator for a long time, that is not really the fiscally responsible way to deal with things. So I just will express that frustration out loud.

To follow up on the chairman's question, I was going to ask this in closed session, but since you were able to answer it in the open, I will ask it. At the locations where the VA missed the opportunity to piggyback on DOD, are you going to deploy at those sites last? Or is a second Cerner team going to have to go to those sites?

Secretary SHULKIN. Well, we don't think we have missed any yet. They are just now implementing in the Pacific Northwest. I think they had their opening 2 weeks ago or a recognition of that. Today, maybe, is their official.

So that is why we are trying to do this quickly. And we recognize you have been extraordinarily responsive in trying to keep up with that timeline. But we haven't missed any sites yet, and so we don't want to be in the position of having to go back and correct for that.

TIMEFRAME TO DEPLOY THE CERNER SYSTEM

Ms. WASSERMAN SCHULTZ. On the timeframe to fully deploy the Cerner system, theirs is a 15-month deployment schedule per location. Is that a timeframe that is set in stone, or are you going to be able to shorten it as you learn best practices?

Secretary SHULKIN. Yes. Working with DOD and the fact that they have been so generous in sharing their lessons and their implementation plans, we can clearly shorten this.

The DOD healthcare system is one-third the size of VA. So let's just, from the start, say ours is a much more complex and larger implementation. But we believe that if the contract is signed that we will be implementing our first site within 18 months. And then it will be this 7- to 8-year rollout that will get you to the full 10-year period.

But we have to implement much faster and more aggressively than DOD, just because the number of facilities that we have are two-thirds more than what they have.

Ms. WASSERMAN SCHULTZ. When I got on the Appropriations Committee, I inherited, as the then-chair of the Leg Branch Subcommittee, helping to bring in for a landing the really unbelievably blown timeline and cost of the CVC. So, at a certain point, we had to bring in GAO to manage the completion of it so that we could stop the bleeding.

IS THE TIMELINE TOO AGGRESSIVE

So I have a little experience in oversight of something this significant, which concerns me—just to use an example of the question I am going to ask you, my husband for years—I am almost always late. My husband will be early to his funeral. And in our 27-

year marriage, he has told me, "Debbie, it is just better to tell me the real time you are going to be here than to give me a time that is a lot sooner than you really likely are going to arrive."

So that begs the question, it took DOD 26 months from generation until contract award, and you have a faster timeline than DOD and a larger system, so is there any concern that your timeline is too aggressive?

Secretary SHULKIN. Well, first of all, I think your example is a very good example we can all understand. But there is no doubt that we are being aggressive with this. But we are also doing business differently, and we are trying to do business differently. Now, that doesn't assure that we are going to be 100-percent successful at this, but I think the right thing to do in this situation is to act with urgency and to be aggressive and to establish sharp timelines.

The major difference that we are going to do in implementing this versus other VA IT projects, which does not have a great history of on-time, on-cost——

Ms. WASSERMAN SCHULTZ. No.

Secretary SHULKIN [continuing]. And we understand that—is we, first of all, have given up on the idea that we are going to be doing software development ourselves. That was the initial plan, which is that we are going to buy commercial, off-the-shelf systems and we are going to rely upon industry partners who have good track records.

Secondly, we are going to do the governance of this project and the oversight of this project directly out of the Secretary's office. That has not been done before. Part of the root cause of some of our problems at VA has been the silos between IT and the health system. And so this is going to report directly to the Deputy Secretary, who will have oversight. And there will be a new governance committee established that will have VHA and IT working as part of that governance structure.

Third is we are using the lessons from DOD. If they weren't talking to us and sharing this, I would be much more concerned. But they are so fully committed to our success that I believe that saves a lot of time and a lot of money for taxpayers.

And, fourth, we are taking advantage of the private-sector CIOs. Mr. Blackburn is going to be on a call with five of the leading CIOs in the country getting their advice, asking what mistakes are likely to happen, and essentially using private-sector input.

I have been a private-sector CEO. I have done EHR implementations. It doesn't mean I have done anything like this or this complicated. Nobody has. But I think we are committed to working with the private sector and DOD in ways that VA before just hasn't been willing to do.

Ms. WASSERMAN SCHULTZ. Mr. Chairman, Mr. Secretary, I look forward to being surprised. Thank you.

I yield back.

Mr. DENT. At this time, I would like to recognize the chairman of the full committee, Mr. Frelinghuysen, for 5 minutes.

The CHAIRMAN. We are admiring of the work you are doing and the fact that you are putting your shoulder to the wheel.

Just let's say for the record, the House did all of its 12 appropriations bills. We are waiting on the Senate. And the first bill out of the hopper was this bill.

Secretary SHULKIN. Yes.

The CHAIRMAN. And may I say for the record, no disagreement, we forward-funded the VA. No one else gets that, and we do it for a reason.

The issue here is that we are about to approve a reprogramming of a certain amount, which commits us to a long-term obligation. And that is why we are here, is just to have some assurances that we know where we are going here. That is really why we are having this hearing here.

ELEMENTS TRANSFERABLE FROM VISTA

For me, just a couple of comments. Is there anything salvageable from what we have already invested in? Which I have indications there is.

And we have other financial systems in a variety of VA facilities that are subpar, ancient, all different.

And I assume you feel that those are systems that need to be replaced, rejuvenated, and whatever.

But, you know, the issue here is we sign on the dotted line with this reprogramming. We are committing this Congress and future Congresses to the implementation of this plan.

We want to get it headed in the right direction.

Secretary SHULKIN. Right.

I think that, Mr. Chairman, you were absolutely correct in all of your comments here and your perspective on this. VA has always shared the goal of getting interoperability and has shared the goal of getting interoperability and has shared the goal of getting to one instance instead of 130 of our EMR. It is just that we thought we would build this ourselves. And so we have been trying to be a software development company. And we have literally spent billions of taxpayer dollars and lots of years and haven't gotten there.

And what we are saying now is that we are going to go to commercial, off-the-shelf technology. But what we have worked on isn't completely wasted. We have a lot that we have achieved that we are going to use in this implementation. Part of why it gives us a little bit more confidence that we will get there and that we can make up on some of these timelines. Because a lot of the work that we have done in process mapping of getting towards a single instance, which we had called VistA Evolution, is not going to be wasted, and we are going to need that.

We are also going to be running our VistA system in parallel while we bring up Cerner, because we cannot afford to let any veterans' healthcare fall down.

Mr. DENT. I would now like to recognize the gentleman from Georgia, Mr. Bishop, for 5 minutes.

Mr. BISHOP. Thank you very much.

Let me welcome you, Mr. Secretary, Mr. Blackburn, Mr. Windom.

CONNECTION TO COMMUNITY PROVIDERS

Let me get right to the point. As you know, the issue of creating a fully interoperable health record for our veterans has been a con-

cern of Congress for a long, long time. It is my understanding that the proposal from Cerner is focused on DOD–VA interoperability but that the strategy to connect community physicians who provide care for veterans is not yet defined.

Given the growth of the Choice and the Community Care program, this challenge is something that really needs to be addressed immediately, particularly in rural areas. I, for one, would be much greater reassured if we knew that you had plans to address the interoperability with the community providers, as well as to ensure that all veterans can benefit from the interoperability.

As such, what provisions are in the Cerner contract that will develop interoperability solutions to improve connectivity between the providers and the community? And by that, I don't mean a Joint Legacy Viewer.

Secretary SHULKIN. Yes. Your question is absolutely the critical question that we have set forth to achieve.

So, first of all, we will achieve DOD interoperability. That is one piece of it. We will achieve better interoperability among the 130 different instances because I practice in the VA; I have to leave my system that I use to go into one across the country. So it is not, even in the VA system, true, easy interoperability.

VA already has several hundred health information exchanges with community providers. So we are doing interoperability with our community providers in the network. As you know, one-third of our care is now out in the community.

Mr. BISHOP. Right.

Secretary SHULKIN. So we are going to already have that.

Cerner, itself, has an interoperability tool that connects with thousands of additional providers with standards that are common. So we will have that.

But we absolutely need to engage other IT vendors, other EHR vendors, besides Cerner, in order to achieve the objective that you have laid out, and that is a program that we have just put out an RFI for to industry to ask how we can best do this and work with them to achieve the goal you have stated.

We call it the digital health platform. It is a central component of achieving the goal that we need for our veterans, which is interoperability with community partners. And we are going to be working with industry to get that done.

CYBERSECURITY CHALLENGES

Mr. BISHOP. One of the real challenges, particularly in this day and time, is going to be the cybersecurity aspects of the Community/Choice program connectivity, as well as the DOD–VA interoperability.

Secretary SHULKIN. Yes.

Mr. BISHOP. So that is going to be a real challenge, and we will be very interested to know how you are going to make that happen.

EHR PROGRAM MANAGEMENT OFFICE

You mentioned that the electronic health record program will be run out of your office. Will you set up a new sub-office? Will we see this in the fiscal year 2019 request? Or are you going to try to do it——

Secretary SHULKIN. Yes. This is all part of the overall program cost.

And, Scott, you may want to talk about the PMO and how we are going to do this.

Mr. BLACKBURN. Absolutely.

So there will be a separate office. That is currently being led by Mr. Windom. So it will be a program management office that will be made up of both clinicians from VHA as well as technologists from OI&T. We feel it is incredibly important to put them together in one team, one integrated team that is working together, with a joint governance structure over that that includes the CIO, that includes the Under Secretary of Health and the Deputy Secretary.

PROJECT GOVERNANCE

Mr. BISHOP. Quickly, let me ask you, where you have these CIOs working together, for key decision points that might impact both departments, who will serve as the responsible personnel that is accountable? DOD? VA? Who is going to be ultimately responsible for making those decisions?

Mr. BLACKBURN. I will defer to Mr. Windom on the joint governance structure.

Mr. WINDOM. We believe that governance is a critical part. We want to stay on converging paths to seamless care, not diverging paths. So governance has been something we have been working on hand-in-hand with our DOD counterparts, and we have created an interagency governance board. That interagency governance board is chaired at the highest levels. We would like to think that much of the decisionmaking and results will——

Mr. BISHOP. Who will chair that?

Mr. WINDOM. Well, it will be chaired at the DepSec level for us, and it is at the AT&L level for DOD.

And so that board, there will be technical and functional governance elements under those levels that, hopefully, most problems will be resolved in.

There will be participation by Cerner Corporation, as a nonvoting member, because they are the developer of the software. DOD, as you know, has Leidos as a prime contractor, so they will be a participant.

So it is important that we all stay in tune to the changes that each side is making or desires to make, DOD–VA, with a clear understanding that we will manage, you know, in a configuration management schema, those changes. Because, typically, most changes are good for both sides of the enterprise, not for a single side.

So, sir, that construct under that interagency platform is going to be how we are going to ensure that we stay aligned in our methodologies and moving forward.

Mr. DENT. I would like to recognize Mr. Jenkins for 5 minutes.

Mr. JENKINS. Thank you, Mr. Chairman.

And, folks, thanks for being with us.

Two areas of inquiry.

OPIOID CRISIS

One, we are amidst, nationally and certainly at ground zero, an opioid crisis. And I appreciate the work that the VA is doing trying to address this within our veteran population.

We obviously have a patchwork of prescription drug monitoring programs at the State level around the country. We have had issues about trying to make sure the VA is sharing information for these PDMPs and also that the healthcare providers at the VA have full access to the appropriate medical history for best prescribing practices.

Can you reassure me about the interoperability of this system being able to integrate the information from State PDMPs and what the status is on the VA sharing information the other direction, with State PDMPs, about prescribing issues?

Secretary SHULKIN. Yes.

Well, first of all, as you know, the VA is fully committed to complying with the State regulations and the State laws, and we do. That is our current policy, that we use the PDMPs. And it is part of our multifaceted approach to reducing opioid use and one of the reasons why we have a 36-percent reduction in opioid use among veterans since 2010.

We are concerned about data that shows that when veterans leave the VA out into the community that there are actually higher rates of opioid abuse happening out in the community. So this is one of the reasons why this interoperability with community providers is absolutely key to us.

But Cerner Corporation, in this contract, is committed to complying with the State regulations. And that is something that we just won't see any misstep from in the transition.

Mr. JENKINS. Thank you.

The second, I am a big believer that you have to be able to walk before you run. And I know what you are describing here is running with an integrated system, working with community partners, but I still remain very concerned about the existing system and the breakdowns.

PAYMENT SYSTEMS PROBLEMS

Let me just give you an example. I was in my hometown, at Cabell Huntington Hospital, one of the largest hospitals in the State. Many veterans get care there, coupled also with our wonderful VA medical center in Huntington.

But in my meeting with Cabell Huntington Hospital, they were sending claims for the direct VA care to Mountain Home VA Health Center in Tennessee. And they were having a 40-percent rejection rate just because the folks at Mountain Home VA Health Center, as I understand it, generally, maybe not in every case, was sending them to the wrong VA center.

So Cabell Huntington Hospital has to start stamping each claim that they submit to say where Mountain Home needs to send it. And they have improved. They are at the 25- or 30-percent level.

And then, when Cabell Huntington tries to call, very often, nobody answers; there is no ability to leave a message.

So, fundamentally, I still think we have serious, serious payment system problems. We have an administrative challenge, to be polite about it. Because this is to the tune, for a community of 50,000 people, a hospital, they have accounts receivable to the tune of $7-million-plus waiting for payment. That impacts healthcare delivery for our veterans.

So what assurances can you provide that, while we are thinking visionarily about this new integrated EMR–EHR system, we are still making a commitment to getting the payments done in a timely, accurate fashion and addressing the flaws in the existing system?

Secretary SHULKIN. Yes. You know, I come from the world of running hospitals, and I fundamentally believe that if you deliver a service, you need to be paid for that. And the VA, in too many cases, as you are saying, is falling short on that.

There is, again, enough blame for this to go around. We have had problems with our third-party administrators in some cases, our contractors and payments. But, clearly, a lot of the responsibility is also on the VA.

We are working very hard to improve those areas of communication, that what you are describing is unacceptable. We are trying to build timely payment standards into new Choice legislation that we hope that you will soon have an opportunity to consider. And we are trying to simplify the payment systems, which right now require 100-percent adjudication, which is not an industry standard. You wouldn't find that in the private sector.

So I think that we are trying to move much more to where the private sector has gotten to on timely payments, and we need to do that. And I would be glad to look into your particular situation there so that we can get that corrected, as well.

Mr. JENKINS. Thank you, Mr. Secretary.

Mr. DENT. I would like to recognize the gentlelady from California, Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman.

PROBLEMS FINDING MINORITY & SMALL BUSINESS SUB-CONTRACTORS

Welcome, all of you. Thank you for being here.

Of course, this is a sole-source contract, 10 years. You have been very aggressive, in response to Congresswoman Wasserman Schultz, in terms of getting this done.

Now, Small Business Administration negotiates prime and subcontracting goals with each Federal agency. So, given this contract, given that it has been pending, as we know—I mean, this work has been pending for many, many years, let me ask you a couple of questions just about this in terms of the VA.

Now, I know the VA got a passing grade of B on the prime subcontracting goals of 30 percent of small-business-eligible contracts. That is the VA. Now, your newly negotiated goal for fiscal 2017, actually, that has been downgraded—I don't know why—to only 28 percent.

Now, the VA notes in your report that providing timely patient care requires that we continue to rely on national and regional contracts for procuring healthcare outside the VA system but that the VA will seek subcontracting opportunities for small business.

Now, the VA did exceed its general small-business subcontracting goal of 70 percent, but you failed in all these other categories that are in statute. Let me give them to you.

Okay. You are required 5 percent of all prime subcontracting goals. You reached 2.2 percent for women.

For small, disadvantaged businesses, 5 percent of all prime and subcontracting awards. You got to 1.4 percent. And let me remind you, this is where the minority-owned businesses are, okay? African American, Latino, Asian, Pacific American, 1.4 percent total. That is outrageous.

Service-disabled veteran-owned businesses, 3 percent of all prime and subcontract. You got to 0.3 percent.

And for HUBZones, you have a requirement of 3 percent. You got to 0.5.

Now, given the enormous amount of money Cerner is going to make off of taxpayers in this VA contract, let me ask you what you have required of them to comply with Federal law to meet all of these goals. Because what you are doing, you are going backwards now, in terms of most of these businesses that you should be requiring the subcontracting goals—contractors to reach.

So let me hear your thinking on that and what you are doing about this Cerner Corporation subcontracting goals.

Secretary SHULKIN. Yes. So you are asking about what requirements will we put on Cerner to subcontract with small business and some of the particular——

Ms. LEE. Yeah. In compliance with the law.

Mr. WINDOM. Ma'am, within the terms and conditions of the contract, the VA small-business goals are fully captured. I can't site those for you directly. I can get back to you with those numbers, but I could tell you exactly what percentages are going to whom. What——

Ms. LEE. For Cerner. You are talking about now, for this contract.

Mr. WINDOM. For this contract.

Ms. LEE. Yeah. Okay. For small business. Okay.

Mr. WINDOM. Cerner is fully on board with those—they have to provide as part of the process a small-business plan on how they are going to achieve those goals.

Ms. LEE. Right.

Mr. WINDOM. It is really the enforcement of those terms and conditions that are important.

Ms. LEE. Yes.

Mr. WINDOM. My program management office will be enforcing those goals rigidly. I can't speak for the other elements of the VA. That is all new information to me. But I can assure you that, in overseeing the Cerner contract, those small-business objectives will be of the foremost importance to us to achieve.

Ms. LEE. But, Mr. Windom——

Mr. WINDOM. Yes, ma'am.

Ms. LEE [continuing]. Small-business goals are one. You are not aware of minority-owned-business goals?

Mr. WINDOM. I am absolutely aware of minority-owned-business goals.

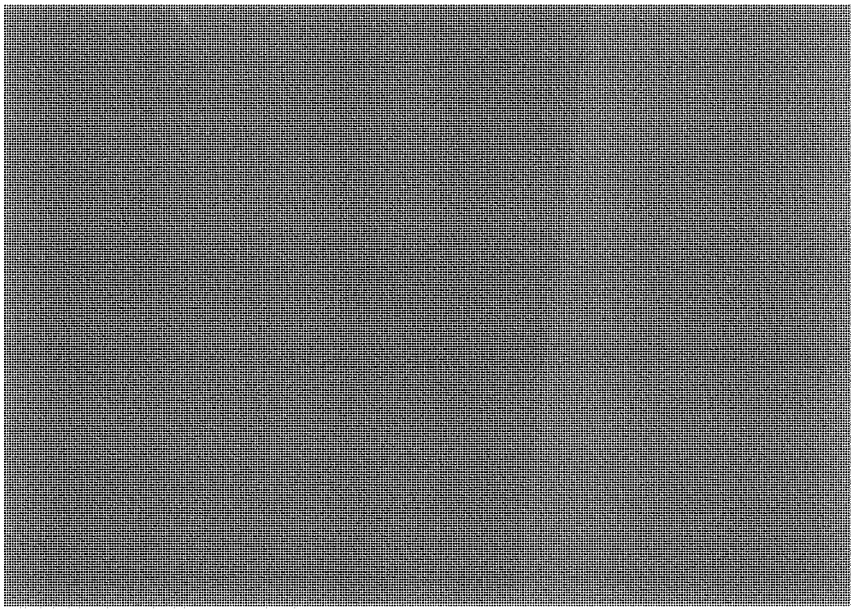
Ms. LEE. Then what are they and what have you required of Cerner for women-owned businesses and minority-owned businesses in this contract?

Mr. WINDOM. Ma'am, the way the contract is broken down, there are—again, I can't site the specific percentages, but each one of those categories have a percentage of the total contract value that they are entitled to be awarded as part of contracted work subcontracted to Cerner.

Ms. LEE. Does anybody have those requirements here?

Mr. WINDOM. I can get back to you. Ma'am, I don't want to cite inaccurate—but I can give you those percentages, broken out by categories, as you requested. That is no problem. As a matter of fact, I may even be able to get it in time during the closed session.

[The information follows:]



Cerner

Department of Veterans Affairs

Electronic Health Record Modernization

Proposal Submission

VA118-17-R-2324

Volume IV: Small Business Subcontracting Plan

November 10, 2017

Cerner

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SMALL BUSINESS SUBCONTRACTING PLAN

Department of Veterans Affairs
Electronic Health Record Modernization

Version 4.0

COMPANY	Cerner
TYPE OF PLAN	Individual Plan
DATE PREPARED	November 10, 2017
SOLICITATION NUMBER	VA118-17-R-2324
ITEM/SERVICE	Electronic Health Record Modernization
INDIVIDUAL PLAN PERIOD	1 December 2017 – 30 November 2027
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SUBMITTED BY	Travis Dalton

1. INTRODUCTION

Cerner Government Services, Inc., a wholly owned subsidiary of Cerner Corporation, is committed to providing the maximum practical subcontracting opportunities to Small Businesses (SBs) including HUB Zone (HUB), Small Disadvantaged Business (SDB), Women-Owned (WOSB), Veteran-Owned (VOSB), and Service-Disabled Veteran-Owned (SDVOSB) in support of the Department of Veterans Affairs (VA) Electronic Health Record Modernization (EHRM) program. Cerner is committed to provide a program to encourage the development of small business concerns and to meet the principles and intent of Federal Acquisition Regulation (FAR) requirements specified in Subpart 19.7 and FAR 52.219-9. This plan is compliant with FAR 52.219-9, and addresses the fifteen elements of FAR 52.219-9(d).

2. GOALS (FAR 52.219-9(d)(1) and (2))

Cerner has assembled an experienced, well-rounded team to deliver the Electronic Health Record Modernization (EHRM) program. As depicted in the table below, Cerner identified $[redacted] of services eligible for subcontracting opportunities, of which $[redacted] is intended to be subcontracted to small businesses. Our team members are comprised of both large and small businesses, and include many of the same team members that are delivering on the Department of Defense's MHS GENESIS Program. Team members include [redacted].

Total IDIQ Ceiling	$[redacted]
Less Travel and ODC	([redacted])
Less Cerner proprietary offerings	($[redacted])
Non-proprietary offerings	[redacted]
Less Cerner provided services	($[redacted])
Total Available for Subcontracting	[redacted]

Proprietary Offerings - Cerner is a leading supplier of health care information technology. We have systems in more than 25,000 facilities worldwide, including hospitals, physician practices, laboratories, ambulatory centers, behavioral health centers cardiac facilities, radiology clinics, surgery centers, extended care facilities, retail pharmacies and employer sites. The VA EHRM Contract is a FAR Part 12 Commercial Item Acquisition, so available opportunities for subcontractors are limited to the non-proprietary components of the Contract. Cerner's Small Business Subcontracting Plan excludes travel and other direct costs as well as the commercial, proprietary components of the VA EHRM proposed solution as described in the Table below. This exclusion includes commercial software and content, related software support services and maintenance services, hardware and related hardware maintenance, data hosting services, transactional services, subscription services, transition services for revenue cycle and innovation, as detailed in the Table and description below.

Total Proprietary Offerings

CLIN	Deliverable/Description	Total Proprietary Offerings
0002AAA	Millennium Enterprise License	$[redacted]
0002AAB	HealtheIntent License	$[redacted]
0002AAD	Transactional Services	$[redacted]
0002C	Software Maintenance	$[redacted]
0002D	Hardware & Hardware Maintenance	$[redacted]
0003	EHRM Hosting and Managed Services	$[redacted]
0010	Innovation and Enhancements	$[redacted]
0012	EHRM Technical Support	$[redacted]
0013A	Transition Services for Revenue Cycle	$[redacted]
Total Proprietary Offerings		$[redacted]

- The VA EHRM Solution (CLIN0002AAA) is comprised of commercial proprietary software, services and content. Only Cerner and, as applicable, Cerner's third-party technology providers can provide certain proprietary components of the VA EHRM Enterprise Software and Non-Enterprise Software. For example, Cerner Millennium Enterprise Software and content contain proprietary licensed offerings, developed at private expense and marketed by Cerner to government and commercial entities around the world. The EHRM Non-Enterprise Software also includes proprietary third-party software and content that was developed at private expense and marketed to government and commercial entities.

- The HealtheIntent Services (CLIN002AAB) are Cerner's software-as-a-service offerings performed on Cerner's proprietary HealtheIntent platform and can only be provided by Cerner. Our HealtheIntent platform is a platform designed to scale at a population level while facilitating health and care at a person and provider level. On the HealtheIntent platform, Cerner offers solutions that help health care systems aggregate, transform and reconcile data across the continuum of care, and manage the health of populations.

- The Transactional services, Subscription services, and Content (CLIN0002AAD) were developed at private expense, marketed and provided to the commercial marketplace and can only be provided by the applicable technology supplier.

- Related software maintenance (CLIN0002C) for the proprietary EHRM Enterprise Software and EHRM Non-Enterprise Software can only be provided by Cerner or the applicable third party technology provider.

- Hardware and related hardware maintenance (CLIN0002D) can only be provided by Cerner or the applicable third party hardware provider.

- Data Hosting Services (CLIN3) are performed in Cerner's state-of-the-art data centers and can only be provided by Cerner and its associates who have requisite knowledge, skill and training on Cerner's proprietary processes, methodology, tools and software.

- Innovation activities (CLIN10) that involve Cerner's proprietary toolsets and software can only be provided by Cerner.
- The EHRM Technical Support (CLIN12) services may involve activities involve Cerner's proprietary software and solutions that only can be provided by Cerner.
- The Revenue Cycle transition services (CLIN13A) are Cerner's commercial proprietary services offering and can only be provided by Cerner.

Non-Proprietary Offering - Cerner's Small Business Subcontracting Plan goals are aligned to the portions of the project that afford small business subcontracting opportunities. Of the total professional services amount, Cerner will provide certain services which are also excluded from the calculation of available subcontracting opportunities for the reasons set below.

As the leading supplier of HCIT, Cerner offers a broad range of professional services that leverage our proven operational capabilities. Although in the commercial marketplace Cerner would normally provide all of the professional services, Cerner has allocated [redacted]% of the overall professional services to subcontractors, and a minimum of 17% of the subcontracting opportunity to small businesses. Cerner plans to subcontract the following services to third parties: Program Management, Deployment/implementation services, Help Desk Services, Training Services, VIP reporting, procedures and process development, Change Management, EHRM and VA System Integration, Data Migration Planning, Sustainment Training, Work Flow Analysis and other services necessary to perform the work effort.

As the healthcare information technology provider of Cerner Millennium, Cerner possesses the proprietary knowledge of the solutions, methodologies and tools as well as proven implementation experience at over 25,000 provider facilities in over 35 countries. Certain roles and responsibilities within Program Management, Change Management, Practical Informatics Institute, Deployment, Sustainment Training and Support will be retained by Cerner as the Prime Contractor for oversight purposes and to meet the Contract delivery schedule and other requirements identified in the PWS.

The total non-proprietary offerings are described in the table below:

CLIN	Deliverable/Description	Total Professional Services Ceiling Price
0001	Program Management - The Contractor shall provide the required services in accordance with (IAW) the Indefinite-Quantity/Indefinite-Delivery (IDIQ) Performance Work Statement (PWS) paragraph 5.1	$[redacted]
0005	VA Enterprise EHRM Baseline Preparation - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.5	$[redacted]
0005H	Organizational Change Management - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.5.7	$[redacted]
0006	Wave Planning and Deployment - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.6, includes all subtasks 5.6.1 through 5.6.13 excluding 5.6.1 and 5.6.2. The full enterprise deployment is anticipated to be completed within the base 10 year ordering period.	$[redacted]
0006BA	SMALL VA Current Site Assessment	$[redacted]
0006BB	MEDIUM VA Current Site Assessment	[redacted]
0006BC	LARGE VA Current Site Assessment	$[redacted]

CLIN	Deliverable/Description	Total Professional Services Ceiling Price
0007AA	Operations and Maintenance	$[redacted]
0007AB	Help Desk Support - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.7.1.2	$[redacted]
0007BA	End-User Sustainment Training - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.7.2.1	$[redacted]
0008	Business Intelligence and Data Analytics - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.8	$[redacted]
0009	Analysis and Migration of Legacy Data - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.9	$[redacted]
00011	Practical Informatics Institute - The Contractor shall provide the required services IAW the IDIQ PWS paragraph 5.11	$[redacted]
Total Non-Proprietary Offerings		$[redacted]

The Non-proprietary offerings will be performed by Cerner as well as subcontractors as described below with the workshare percentages summarized in the Table below:

- Project Management (CLIN0001). Cerner intends to subcontract [redacted]% of the Program Management services to experienced large and small business subcontractors and will retain [redacted]% of the work for oversight and management purposes.

- VA Enterprise Baseline Preparation (CLIN0005):

    - VA Enterprise Baseline Preparation (CLIN0005). Cerner will perform [redacted]% of the necessary activities and tasks to prepare the initial sites for the baseline deployment.

    - Systems Integration (CLIN0005D). Cerner intends to subcontract [redacted]% of the systems integration services to third party subcontractors.

- Change Management (CLIN0005H). Cerner intends to subcontract [redacted]% of the Change Management services to experienced VA contractors with a knowledge and understanding of the Veterans Information Systems and Technology Architecture (VistA) and VistA work flows. Cerner intends to retain [redacted]% of the Change Management services to bring its Cerner Millennium knowledge and years of implementation and Cerner adoption experience to bear to drive appropriate strategy, knowledge, messaging and content.

- Deployment Services (CLIN0006). Given the considerable risk imposed by aggressive IOC schedule and the close coordination with DoD that will be required for success, we will need to provide Cerner resources familiar with the VA client environment as well as with the existing MHS GENESIS client environment. Cerner intends to subcontract [redacted]% of the deployment services to third parties. Based on Cerner's implementation experience in the commercial marketplace as well as more recent experience at a similar Government client, Cerner needs to provide certain key roles to ensure the success of the Program. Given the deployment schedule, it will take time to train third party resources to provide these critical deployment services. For this reason, Cerner intends to provide [redacted]% of the deployment services.

- Site Assessment (CLIN0006BA, BB, BC). Given the critical nature of these services, Cerner intends to provide [redacted]% of the site assessment services. The site assessments will evaluate each site and determine sizing, pricing approach and overall site strategy.

- Operations and Maintenance Service (CLIN0007AA), also known as Cerner's application management services (AMS), are performed in Cerner's state-of-the-art data centers and can only be provided by Cerner and its associates who have requisite knowledge, skill and training on Cerner's proprietary processes, methodology, tools and software. Of these services described above Cerner will provide [redacted]% of these services. Cerner will subcontract [redacted]% of the Regional Alignment Team from these Operations and Maintenance Services. This breakdown of workshare for CLIN 0007AA equals [redacted]% Cerner and [redacted]% Subcontracted work.

- Sustainment/Onsite Desktop/Device Support (CLIN0007AB). Cerner intends to subcontract [redacted]% of these sustainment services and retain [redacted]%.

- End User Sustainment/On-site Training/Over the Shoulder Support (CLIN0007BA). Cerner intends to subcontract [redacted]% of these sustainment services and retain [redacted]% of the total services provided in this CLIN.

- Business Intelligence (CLIN0008). Cerner intends to retain [redacted]% of the business intelligence services due to the need for access to Cerner's proprietary solutions and tools. These services will set up the solution data analytics approach and development work may be required to set up the business intelligence tools for VA.

- Data Analysis and Migration (CLIN0009). Cerner intends to provide [redacted]% of the data analysis and migration services by Cerner associates and engineers on the HealtheIntent team with knowledge and experience with the proprietary HealtheIntent Platform. Cerner plans to subcontract [redacted]% of these services to third parties.

- Practical Informatics Institute (CLIN0011). As the healthcare information technology provider of Cerner Millennium, Cerner will stand up the Practieal Informatics Institute to provide the strategy, content and program materials, which will be [redacted]% of the PII services. Over time, Cerner will subcontract [redacted]% of the PII services to third parties to educate the VA workforce as well as other third party contractors to learn Cerner methodologies to deliver the message and strategy for the program.

The percentage breakdown of non-proprietary offerings are described in the Table below:

CLIN	Deliverable/Description	Cerner %	Subcontractor %
0001	Program Management	[redacted]	[redacted]
0005	VA Enterprise EHRM Baseline Preparation	[redacted]	[redacted]
0005D	System Integration	[redacted]	[redacted]
0005H	Organizational Change Management	[redacted]	[redacted]
0006	Wave Planning and Deployment	[redacted]	[redacted]

CLIN	Deliverable/Description	Cerner %	Subcontractor %
0006BA	SMALL VA Current Site Assessment	[redacted]	[redacted]
0006BB	MEDIUM VA Current Site Assessment	[redacted]	[redacted]
0006BC	LARGE VA Current Site Assessment	[redacted]	[redacted]
0007AA	Operations and Maintenance Service	[redacted]	[redacted]
0007AB	Help Desk Support	[redacted]	[redacted]
0007BA	End-User Sustainment Training	[redacted]	[redacted]
0008	Business Intelligence and Data Analytics	[redacted]	[redacted]
0009	Analysis and Migration of Legacy Data	[redacted]	[redacted]
0011	Practical Informatics Institute	[redacted]	[redacted]

Under Cerner's Small Business Subcontracting Plan, services in the amount of $[redacted] are eligible for subcontracting opportunities. To the extent that the VA EHRM Program is fully deployed and task orders are awarded and fully funded as projected in Cerner's Price Proposal, Cerner's goals, expressed in terms of percentages and planned spend, of total planned subcontracting dollars, for the use of SBs, VOSB, SDVOSB, HUB, SDB, and WOSB concerns as subcontractors include:

a) Estimated TOTAL dollars planned subcontracting to be subcontracted to all types of concerns for labor services:
Planned Spend: $[redacted] *= 100%*

b) Total dollar goals estimated to be subcontracted to large business concerns (or classified as other than small):
Planned Spend: $[redacted]

c) Total dollars estimated to be subcontracted to all small business concerns (including ANC's and Indian Tribes), **SB, VOSB**, **SDVOSB**, **HUB**, **SDB**, and **WOSB**:
Planned Spend $[redacted] *= 17% of Total*

d) Total dollars estimated to be subcontracted to **VOSB**, including SDVOSB:
Planned Spend $[redacted]

e) Total dollars estimated to be subcontracted to **SDVOSB** *(Note: This is a subset of veteran-owned):*
Planned Spend $[redacted]

f) Total dollars estimated to be subcontracted to **SDB** (including ANCs and Indian tribes):
Planned Spend $[redacted]

g) Total dollars estimated to be subcontracted to **WOSB**:
Planned Spend $[redacted]

h) Total dollars estimated to be subcontracted to **HUB**:
Planned Spend $[redacted]

3. PRODUCTS AND/OR SERVICES TO BE SUBCONTRACTED (FAR 52.219-9(d)(3))

The principal products/services that Cerner anticipates obtaining from small businesses of all types are labor services. Cerner obtains labor services from two (2) distinct groups of labor service vendors: (1) Consultants; and (2) Subcontractors, as defined as follows:

A "Consultant" is typically an individual, sole proprietorship, or small company under which one or more specific individuals are utilized on a Cerner subcontract or prime contract to perform billable work on behalf of and in support of Cerner customer under the applicable subcontract or prime contract.

A "Subcontractor" is typically a partnership or corporation which Cerner contracts with to utilize the Subcontractor's resources to perform services under a Cerner subcontract or prime contract.

Services	Large	Small	HUB Zone	SDB	WOSB	VOSB	SDVOSB
Consultant Labor Services		•		•		•	
Subcontractor Labor Services		•		•		•	

4. METHOD USED TO DEVELOP SUBCONTRACTING GOALS (FAR 52.219-9(d)(4))

Cerner has established its small business goals based on statutory goals put in place by the U.S. Small Business Administration (SBA) for Federal agencies.

5. METHOD USED TO IDENTIFY POTENTIAL SOURCES (FAR 52.219-9(d)(5))

Cerner performs ongoing market research to identify potential SBs with the capabilities to provide health care information technology services. Cerner has relationships with SBs and will focus on continuously identifying new SBs that can provide value to the VA EHRM program. Accordingly, we focused our initial teammate selection on SBs with the ability to be competitive. We have given adequate consideration of the potential performance across qualified SBs, VOSB, SDVOSB, HUB, SDB, and WOSBs. Among the sources available to Cerner to identify potential SB subcontractors are bidder's lists developed and maintained by Cerner, the SBA, System for Award Management (SAM), and industry trade associations including the annual National Veterans Small Business (NVSB) Conference and other VA-focused events.

6. USE OF INDIRECT COSTS IN SUBCONTRACTOR GOALS (FAR 52.219-9(d)(6))

Indirect costs ☐ have ☒ have not been included in the dollar and percentage subcontracting goals stated above.

7. PLAN ADMINISTRATOR AND DUTIES (FAR 52.219-9(d)(7))

The following individual will administer the subcontracting program:

COMPANY	Cerner Government Services, Inc
NAME	Director
TITLE	Supply Chain Management
ADDRESS	2800 Rockcreek Parkway North Kansas City, MO 64117
TELEPHONE	610-219-4748
E-MAIL	Nelson.Gray@Cerner.com

Duties. The Plan Administrator shall have general overall responsibility for Cerner's SB Plan, to include:

- Monitor plan attainment and reporting of subcontracted SB, VOSB, SDVOSB, HUB, SDB and WOSB concerns;
- Confirm that a subcontractor representing itself as a HUB SB concern is identified as a certified HUB SB concern by accessing the SAM database or by contacting SBA;
- Monitor awarded subcontracts to ensure fulfillment contracts for SB, VOSB, SDVOSB, HUB, SDB and WOSB concerns;
- Oversee the establishment and maintenance of contract and subcontract award records;
- Monitor the company's performance and make any adjustments necessary to achieve the subcontract plan goals;
- Attend SB trade shows, conference, industry events to pursue new SBs;
- Prepare and submit timely reports against the SB Plan; and,
- Coordinate the company's activities during compliance reviews by Federal agencies.

8. EQUITABLE OPPORTUNITY (FAR 52.219-9(d)(8))

Cerner will make reasonable efforts to afford SB concerns an equitable opportunity to compete for subcontracts as proposed earlier in this plan. These efforts may include one or more of the following activities:

- Maintain source lists of eligible small businesses by SB category and areas of expertise;
- Solicit proposals from eligible and viable suppliers, as appropriate; and,
- Attend SB trade shows, such as the NVSB, to pursue new SBs.

9. ASSURANCES OF CLAUSE INCLUSION AND FLOW-DOWN CLAUSE (FAR 52.219-9(D)(9))

Cerner agrees to include the FAR Clause 52.219-8, "Utilization of Small Business Concerns" in all subcontracts relative to this subcontract plan that offer further subcontracting opportunities, and will require all subcontractors (except small business concerns) that receive subcontracts in excess of $650,000 ($1,500,000 for construction) to adopt a plan that complies with the requirements of the clause at 52.219-9, SB Subcontracting Plan.

10. REPORTING & COOPERATION (FAR 52.219-9(d)(10))

Cerner agrees to:

- Cooperate in any studies or surveys as may be required;
- Submit periodic reports so that the Government can determine the extent of compliance by the offeror with the subcontracting plan;
- Submit the Individual Subcontracting Report (ISR) and/or the Summary Subcontract Report (SSR), in accordance with the paragraph (l) of this clause using the Electronic Subcontracting Reporting System (eSRS) at http://www.esrs.gov . The reports shall provide information on subcontract awards to SB concerns (including ANCs and Indian tribes that are not SBs), VOSB, SDVOSB, HUB, SDB (including ANCs and Indian tribes that have not been certified by the SBA as SDB), WOSB, and Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in agency regulations;
- Ensure that its subcontractors with subcontracting plans agree to submit the ISR and/or the SSR using eSRS;
- Provide its prime contract number, its DUNS number, and the e-mail address of the offeror's official responsible for acknowledging receipt of or rejecting the ISRs, to all first-tier subcontractors with subcontracting plans so they can enter this information into the eSRS when submitting their ISRs; and,
- Require that each subcontractor with a subcontracting plan provide the prime contract number, its own DUNS number, and the e-mail address of the subcontractor's official responsible for acknowledging receipt of or rejecting the ISRs, to its subcontractors with subcontracting plans.

Reports are submitted within 30 days after the close of the required reporting period.

11. RECORDKEEPING (FAR 52.219-9(d)(11))

Cerner will maintain records concerning procedures that have been adopted to comply with the requirements and goals in the plan, including:

- Source lists that identify SB, VOSB, SDVOSB, HUB, SDB, and WOSB concerns;
- Organizations contacted in an attempt to locate sources that are small business, VOSB, SDVOSB, HUB, SDB, and WOSB concerns;

- Records with FAR-specified information on each subcontract solicitation resulting in an award of more than $150,000 to indicate whether a small business concern was solicited, and if not why, and if applicable, the reason award was not made to a small business concern;
- Records of any outreach efforts to contact:
  - Trade Associations,
  - Business development organizations,
  - Conferences and trade shows to locate small, HUB, SDB, and WOSB and VOSBs sources;
- Internal records which may include:
  - Workshops, seminars, training, etc., and
  - Monitoring performance to evaluate compliance with the program's requirements.

12. ASSURANCE OF AWARD OF SUBCONTRACTS TO SMALL BUSINESS CONCERNS (FAR 52.219-9(d)(12))

Cerner is committed to making good faith efforts to acquire services from small business concerns listed in this proposal. Cerner has entered into Teaming Agreements with small businesses for portions of the VA EHRM project. Cerner is fully committed to awarding work to these small businesses. To demonstrate this effort, Cerner has invited a team member, AbleVets, to many meetings with the VA. Cerner has also demonstrated compliance with this requirement by using AbleVets assistance in the preparation of Task Order templates and subcontracts for VA EHRM.

13. UTILIZATION OF SMALL BUSINESS CONCERNS USED IN BID/PROPOSAL (FAR 52.219-9(d)(13))

Cerner is committed to its goals to subcontract portions of applicable work to small businesses. Cerner will submit updates to small business goals in accordance with the contract and FAR. If Cerner is unable to meet small business goals, Cerner will provide the Contracting Officer with a written explanation of inability to meet goals and shall provide details to demonstrate why Cerner was unable to meet the small business goals. Cerner will provide this written explanation within thirty days of contract completion.

14. SUBCONTRACTOR DISCUSSION WITH CO (FAR 52.219-9(d)(14))

Cerner agrees not to prohibit a subcontractor from discussing with the Contracting Officer material matter pertaining to payment to or utilization of a subcontractor.

15. TIMELY PAYMENTS TO SUBCONTRACTORS (FAR 52.219-9(d)(15))

Cerner is committed to timely payment of its suppliers including its SB subcontractors on time and in accordance with the terms and conditions of the underlying contract. Cerner's payment to subcontractors is based upon agreed-upon payment terms with each subcontractor. Cerner agrees

to notify the Contracting Officer when a materially reduced or significantly untimely payment is made to a small business subcontractor under this contract.

16. UTILIZATION OF SMALL BUSINESS CONCERNS USED IN BID/PROPOSAL (FAR 52.219-9(d)(16))

Cerner is committed to the maximum practicable utilization of SBs as subcontractors to fulfill the subcontract plan. Cerner shall monitor on a monthly basis its performance against the stated subcontracting goals herein and shall report on its performance according to the reporting requirements defined in (10).

This SB Subcontracting Plan was submitted by

Signed: _____

Typed Name: MARLE ELKINS

Title: CONTRACTS SPECIALIST

Date Signed: 16 NOVEMBER 2017

Plan Approved by (Government official): _____

Typed Name: _____
Contracting Officer

Date Approved: _____

Ms. LEE. Thank you.

And, Mr. Secretary, let me just ask you, just overall, generally, what is going on over there? I mean, you know, we are trying to ensure parity and equal opportunity and nondiscrimination, and here you have 1.4 percent this year for minority-owned companies?

Secretary SHULKIN. Well, first of all, we are committed to this. Those are numbers that are different numbers than I have, so I would like the opportunity to be able to sit down with you and——

Ms. LEE. This was from the Department of Veterans Affairs, your procurement division.

Secretary SHULKIN. In what time period?

Ms. LEE. This is February—we requested it for February 2017. Subcontracting data as of March 14, 2017, for fiscal 2016.

Secretary SHULKIN. Yes. As I said, those are different numbers than I have seen.

As you know, the Kingdomware decision has completely changed the approach that the Department of Veterans Affairs is doing for contracting with small businesses. And we have had a strategic pause and have relaunched to be able to meet these objectives.

This is a goal that we share, we take seriously. As you said, our overall goals are always above our targets here. And if we are falling short in some areas, I want to make sure that you and I have the same information, but I can tell you we are going to be committed to improvements. If the data that I have is different than what you have, then I want you to have that information as well too.

Ms. LEE. Okay. Thank you. And I look forward to getting the specifics on Cerner. Thank you.

Mr. WINDOM. Absolutely, ma'am.

Mr. DENT. Okay. Mr. Taylor is recognized for 5 minutes.

Mr. TAYLOR. Thank you, Mr. Chairman.

And, Mr. Secretary, thanks for being here.

Let me first say, number one, let me echo some of my colleagues' comments in talking about how long it has taken. And I just appreciate that you are a hard charger, that you are aggressively moving to get the damn thing done. Because it is inexcusable, in my opinion, how it has been before you and I both got here.

But I appreciate that you are doing that, but we do have some questions, of course, on some of the cost savings and timeline issues.

But I do want to address one thing that I just heard that I think is important. Sure, you know, it is extremely important for the VA to meet statute, to meet goals, in terms of service-disabled veterans and minority- and women-owned businesses and stuff like that. I am curious what Cerner's own goals are. But, at the same time, I don't want forced equality on unequal things, in terms of understanding that those statutes and goals are overall in the VA Department, so if there is a specific contract that there aren't qualified folks that can do the work, if we force that to happen, then you are hurting veterans.

So I definitely want to say that for the record. That is not something that I want to see happen. But I do, of course, you know, like my colleagues, want you guys to meet your goals and statute.

That being said, a couple quick things. Let's see.

IMPACT OF FAILURE TO RECEIVE REPROGRAMING

Let's say you aren't able to get this reprogram, these moneys, how will that affect you? What would the timeline be? What would the cost be? Would it be a complete stop for your efforts?

Secretary SHULKIN. Yes, we think it will add—and, Mr. Windom, please correct me if I am not being as accurate, because we want to be as fully transparent as we can in open session. We think it will add at least 5 percent to the total project cost if we miss that alignment with the Department of Defense.

Mr. TAYLOR. So, on the alignment—so it would seem that they are actually getting the best efficiency, the DOD, as opposed to your guys, because you are much bigger and you are more complex, which is fine. That is great. We want to make sure you guys are there.

In terms of if you didn't have the DOD in this, what would that also be in terms of cost and timeline?

Secretary SHULKIN. Well, it would be a longer timeline and more expensive.

Mr. TAYLOR. No question. No question.

Secretary SHULKIN. I mean, in closed session, Congressman, we would be glad to share with you what we believe we have been able to negotiate in terms of efficiencies.

I do believe we have achieved substantial savings and efficiencies and timelines because of DOD's experience here. And we have also learned from them what they would do if they could do it over again so that we are not making the same mistakes, which are costly, to make mistakes.

Mr. TAYLOR. When you are speaking about your community partners—which, in my area, I know that you guys do have that, you do have some exchange in information there.

Secretary SHULKIN. Uh-huh.

ADDITIONAL FUNDING TO COMMUNITY INTEROPERABILITY

Mr. TAYLOR. Is that going to be another appropriation to make sure—obviously, Cerner has 27,000 facilities that use their information. Is that an easy fix, to be able to talk to community partners and everything? Or is that something that you will come back to us and ask for more money for?

Secretary SHULKIN. Yes, we can absolutely take advantage of the health information exchanges that already exist within VA. We have 700 of them. And it is built into the contract to take advantage of Cerner's interoperability with community partners.

This Digital Veterans Platform, which is to seek outside industry to help us create the true interoperability that, frankly, everybody in healthcare is looking for—this isn't just a VA issue. We think VA and DOD can lead this for the country. That digital veteran platform, right now we are just going out and asking an RFI, request for information, that will turn into an RFP for outside industry help.

And so we don't anticipate—we are not asking for an appropriation for that for several reasons: We don't anticipate that happening in these next couple fiscal years, and the work that does happen will be funded internally at VA. But, also, healthcare tech-

nology is changing so rapidly and there are so many new advances that we don't exactly know what that is going to look like.

Mr. TAYLOR. Will this system allow for you to be—you know, that we are not building on legacy systems and MS–DOS and all that stuff but——

Secretary SHULKIN. It automatically includes the new advances, the new updates——

Mr. TAYLOR. With software that just changes——

Secretary SHULKIN. Absolutely. That is part of this contract negotiation.

100 PERCENT INTEROPERABILITY GUARANTEE

Mr. TAYLOR. Can you guarantee 100 percent after this change, if we, you know, reprogram these funds, that you will speak to DOD—or that the interoperability will be 100 percent, DOD and VA?

Secretary SHULKIN. I don't think I have ever guaranteed anything 100 percent. But Mr. Windom is willing to.

Mr. WINDOM. I mean——

Secretary SHULKIN. Yes.

Mr. TAYLOR. He has been shaking his head over there.

Mr. WINDOM. I am willing to say that, because we will be on the same Cerner Millennium platform. We will be hosting our data in the same hosting facility. We will communicate seamlessly across the respective DOD and VA environments because of those reasons. So I expect it to be 100 percent. And I am a veteran, so I am banking on it.

Mr. TAYLOR. All right.

Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Mr. DENT. At this time, I would like to recognize the gentleman from Ohio, Mr. Ryan, for 5 minutes.

Mr. RYAN. Thank you, Mr. Chairman. I appreciate it.

Thank you, Mr. Secretary. Thank you for your service.

Gentlemen, we appreciate you and all the work that you do.

ALTERNATIVE MEDICINE FOR OPIOID ADDICTION

I come from Ohio, and we have, as you know, an opiate epidemic that is of immense proportions for us. In 2016, we lost 4,000 of our fellow citizens in the State of Ohio to overdose, primarily from opiates. As you know, in 2016, we lost over 60,000 people across the country to overdose deaths, more than we lost in the Vietnam War.

So this is something that we continue to struggle to deal with. And I know, Mr. Secretary, that we have talked about this before.

Last month, I noticed that another substantiated report was released by the VA Office of Inspector General following a confidential complaint that the VA clinic in Baltimore, Maryland, was failing to provide appropriate quality control through the opioid treatment program.

A 2014 investigation revealed a disturbing lack of attention on opioid management. Only 6.4 percent of new patients were prescribed opioids in accordance with the clinical practice guidelines. For our highest-risk veterans, those with active substance use diseases prescribed opioids for more than 90 days, less than 19 per-

cent received appropriate testing and therapy, with some clinics providing no testing and therapy at all. The death rate from opiate overdose among the VA is almost double the national average. And issues span many, many facilities.

Further complicating the opioid overprescription problem is a lack of appropriate software in our clinics. As we discuss electronic records and electronic health record management, now is the right time to also address including appropriate software to provide opioid oversight.

What is the VA doing nationwide and in communities like mine in Ohio to implement technology solutions to assist clinicians in delivering improved and preventative patient care so that opioid prescriptions and other medication are properly prescribed?

Secretary SHULKIN. Well, we share, Congressman, your absolute concern and believe that, although we have begun to really focus on opioid safety in 2010, that we need to do much more on this. And so I have personally participated in the President's commission for opioid reduction and addiction, and we are going to redouble all of our efforts. So, when we find situations like the IG did in Baltimore in 2014, that was really a call to doing more in terms of oversight and action.

In terms of technology, we have something called the Opioid Safety Initiative that has a dashboard. We can track opioid prescribing not only by facility, by clinic, by provider. And that triggers for us the ability to go in and intervene with the provider, using academic detailing, which is education by our pharmacists and by other subject-matter experts; by developing alternatives to prescribing medication. We adhere to the stepped-care management approach, the DOD–VA guidelines that do not go first to opioids but look for alternatives. We are investing heavily in complementary or integrative medicine approaches as alternatives in pain management.

But, as you know, 50 percent of the people we care for in the VA system complain of chronic pain. So this is a very tough population to get their pain level correctly, and simply not prescribing is not always the best answer either.

So we are working on this. We are using technology. It is going to be built in to the work that we have done, built in to a new electronic health record. And we are going to stick at this and actually, I hope, be one of the leaders in this in the country to try to solve this problem.

Mr. RYAN. So are you seeing steps in the right direction? I mean, you are looking at, you know, only 19 percent received the appropriate testing and therapy.

These are high-risk populations, as you know. And they are in a lot of pain. So——

Secretary SHULKIN. Right. Those are referring to urine tests for concomitant benzodiazepine use—again, something that we think is a risk, when you put a patient on both an opioid and a benzodiazepine. And being able to track those urine tests to make sure that there are not other drugs being used, that is part of the State prescription data monitoring program, as well.

So this is really a very multifaceted program. Nineteen percent, of course, is not anywhere near what is acceptable. If you went

back to Baltimore today—that was 3 years ago—you would find much higher rates. And we do have the ability to track this now. That is how the IG was able to find those rates.

I have recently been to facilities in Cleveland. We actually brought the entire commission, Governor Christie and Congressman Kennedy and others, there to Cleveland because they are one of the leaders in the country in the lowest rates of opioid prescribing. So we are taking those best practices from Ohio and spreading them throughout the country.

Mr. RYAN. You talked about the stepped-care management approach. Can you just walk us through for 30 seconds—if you can indulge me, Mr. Chairman—of what those steps are? Because I think that is an important point that we kind of ignore. The default position, give the scripts. There are these other approaches. Can you talk to us a little bit about what those are?

Secretary SHULKIN. Sure.

First of all, all of our stepped-care protocols and our VA–DOD guidelines for pain management are all publicly available. So we share these freely with anybody who wants to, because we think they are very good work.

But what it basically says, as a prescribing doctor—and, as you know, I am a practicing physician—you do not start with reaching for your prescription pad or, now, your computer mouse and prescribing opioids, that you take people through what would be a reasonable approach for pain management and starting with the least addictive options and, often, nonpharmacologic options, if that is appropriate.

One of the recommendations that has come out nationally—and you have seen CVS actually take a lead in this—is not prescribing a month's worth of drug but really seven days' worth of drug. Part of the problem of addiction is not even to the person you are prescribing, but it is that they put the remaining drugs in their medicine cabinets and their kids get them or somebody else in the family gets them.

So there are so many things that we can do with this stepped-care approach of how you adequately get to a point where you would prescribe opioids.

Mr. RYAN. Using acupuncture? What are the——

Secretary SHULKIN. Absolutely.

Mr. RYAN. Are we going to have another round, Mr. Chairman?

Mr. DENT. Yes. We are going to go into closed session.

Mr. RYAN. Okay. I will get you next time. Thanks.

Mr. DENT. Mr. Womack is recognized for 5 minutes.

Mr. WOMACK. Thank you.

LENGTH OF TIME TO DEVELOP EHR

Mr. Secretary, gentlemen, thank you for being here.

I am from Arkansas, and I know sometimes we are stereotypically slow. We have been doing this—in your testimony, you talked about how we have been in this discussion now for 17 years, how we have been trying to address this issue—not you guys, because you haven't been doing it that long. And I commend you for the decision to go to the platform. It just would seem to me

that that was a decision that should have been made a long time ago.

And I make this observation not because of the money that we have spent and the difficulty getting this interoperability, as we call it, but because it just makes absolute sense to me that if you are going to want to talk to DOD, if VA and DOD are going to talk together, they should be on the same platform.

Am I missing something as to why we have been in this rut now for 17 years?

Secretary SHULKIN. I think it is important to understand why this has happened, because what it says is it is at risk of happening again.

In 2011, on March 5, 2011, Secretary Shinseki and Secretary Gates, I believe it was, committed, probably in a hearing room like this, that they were going to do it. And I believe that they meant that. I believe that they meant that. And then what happened is Secretaries change and Congress changes, and all of a sudden people say, no, we are going to go a different direction.

So I think what is important is, if we get your support in moving forward, that we do not allow that to happen, that we stay—because this is the right decision. This is the right thing for veterans. And so we have to stick at this.

And it is going to be hard, and there are going to be stumbles. That is why I never say 100 percent. But this is something that we have to get done for the country. And, frankly, the fact that we are following DOD on this gives me greater assurance that we can get this done.

TRANSITIONING FROM THE VISTA SYSTEM

Mr. WOMACK. The only experience I have in anything along this line, on a much, obviously, smaller scale, was I was a mayor once upon a time, and our court system had a bad computer system, and they went to a new system, which was fine, but they made one real major error, and that is they scrapped the old when they transitioned.

Secretary SHULKIN. Right.

Mr. WOMACK. It wasn't much of a transition, but they just scrapped the old.

So, in your testimony, you talked about keeping the VistA system alive. What does that mean? And how long can we expect that we have two systems kind of running simultaneously?

Secretary SHULKIN. Right. So we have 130 VistA systems. Part of what we are planning on doing is we will shut them down one at a time. When we have a successful Cerner implementation and we are confident, we can shut that one down, start to save some money. But by the time we get to the very last medical center at the end of this full 8-year implementation after we start, that will be when we can finally turn off the system.

And, by the way, even then, I think there are 37 subsystems that we haven't figured out yet how to transition off of VistA. Now, we are working on that.

But we are planning on running a dual system for the foreseeable future because we don't want to have what happened to your

court system. I mean, we can't afford to put veterans' health at risk.

Mr. WOMACK. Absolutely.

BEST PRIVATE SECTOR MANAGEMENT PRACTICES

And then, finally, Mr. Secretary, you have been to my district, and you know how interested I am in seeing that our Federal bureaucracy learn best management practices from the private sector.

Secretary SHULKIN. Yes.

Mr. WOMACK. You have personally been to my district to witness that, talk with people.

In the testimony earlier—and I think it was Mr. Blackburn that talked about, I kind of look at it as third-party validation. You have some kind of a CIO board, people from outside the universe, that are going to be looking at the process that we are implementing, this Cerner platform.

Are you at liberty to say who these people are? Do they have a connection to Cerner? Is there any potential, you know, for a conflict of interest in that regard?

Mr. BLACKBURN. From what I have seen, I think the whole American medical community that I have spoken to wants to see us succeed.

So, as an example, this afternoon, I will spend 2 hours on the phone with the CIO of the Mayo Clinic, the CIO of Partners HealthCare, the CIO of Johns Hopkins and Kaiser Permanente. And they will be providing feedback, you know, on—they are reviewing the contract, they are taking a look and saying, hey, you know, here are some of the things that we would do differently, providing us feedback and helping coach us.

As I have reached out to various academic, medical, and healthcare providers, everybody is rooting for us. This is going to be a game-changer for American healthcare. They are providing input. We are even talking about borrowing talents that have gone and done these implementations.

But I would say the support that we have gotten from the healthcare community is fantastic.

Mr. WOMACK. Very good.

I yield back.

Mr. DENT. Thank you, Mr. Womack.

At this time, I would like to recognize the gentleman from California for 5 minutes, Mr. Valadao.

Mr. VALADAO. Thank you, Mr. Chairman.

Thank you, gentlemen, for appearing today.

PORTABLE ACCESSIBILITY TO THE EHR

I personally would like to applaud your decision to adopt the same electronic healthcare system as the DOD. Obviously, for nearly two decades, the VA has been seeking to achieve this interoperability between VA's VistA and the DOD system. It makes much more sense to me if both DOD and VA utilize the same system.

There has been some debate recently about a veteran's lack of ability to access their personal healthcare information. Do you foresee in the transition the establishment of a secure, patient-cen-

tered, portable medical records system, that a veteran can access their own comprehensive medical records?

This is something that has been available to the private sector for quite some time, so it is only natural we afford the same ability to our veterans as well.

Secretary SHULKIN. Yes. Well, I may ask one of my colleagues just to chime in with the details. But our system now, My HealtheVet, is used by millions of veterans. It is a portable system where they are able to access and message with their providers. Used probably more extensively than any other system in the country. So we believe in that. We think that is important.

The transition of that over to Cerner, maybe I would ask Mr. Windom to talk about that.

Mr. WINDOM. And I will defer to Mr. Blackburn, but I can say simply, yes, mobility, the ability to access your record via your phone, via web-based access, definitely at the forefront of the terms and conditions of our contract and that we are pursuing all of the state-of-the-art technology that the commercial environment can produce.

So, Mr. Blackburn, I will pass to you.

Mr. BLACKBURN. I agree. And, you know, as an example, I think I am personally a good example. I am a veteran, an Army veteran. The DOD has a part of my healthcare record. I got out of service, moved back to my hometown of Boston, where Partners HealthCare had part of my healthcare record—I then moved to Cleveland. Cleveland Clinic has part of my healthcare. When I came to the VA 3 years ago, I enrolled in VA healthcare and get my care right now at the Washington VAMC Orange Clinic. I also get care in the community.

Every single one—and I think I just named about five different entities that have different pieces of my medical record that, right now, are not shared well. I had to print out my Cleveland Clinic records and give them to my VA doctor so that he had them. My VA doctor does use the Joint Legacy Viewer, but I got out in 2003, so not much is in there. My records were destroyed in a flood.

So, with that, the ability for a veteran or a citizen to be able to get those pieces and put them together is something that is coming. And we are very excited that this will begin to facilitate that process by linking DOD and VA, with the Digital Veterans Platform beginning to link in all these other systems as well.

It will take a little bit of time to get to where we are going to be in 10 years, where you are going to have this all together on your iPhone, but we are taking the first steps to get there.

Mr. VALADAO. All right.

PROTECTION OF VETERANS' PERSONAL IDENTITY INFORMATION

And then I am going to go in the opposite direction, because, obviously, access means there is an issue with security.

So, Mr. Secretary, one of the issues I have focused on in my career and my actual first piece of legislation I ever signed into law had to do with securing someone's ID and their personal information. Government agencies have to take steps to protect people's personal information.

Can you speak to the cybersecurity enhancements the VA is undertaking in this transition? This system will obviously contain the very sensitive personal information of millions of veterans. What is the Department doing to ensure the safety of that information?

Secretary SHULKIN. Yes.

Mr. Windom, do you want to talk about the cybersecurity requirements in the contract?

Mr. WINDOM. I will touch on—and then I will defer to Mr. Blackburn again.

I come from the DOD side of the house. And, you know, the OI&T efforts right now are leveraging fully the security posture of DOD. And I can assure you the level 2, 3, 4, 5 certifications that exist within the framework of DOD's security posture are being adopted fully. We just had a session with DOD to highlight the importance of the reciprocity agreements that would be necessary between VA and DOD in order to leverage their posture fully. Those are being consummated as we speak.

So there is not going to be this separate VA security posture, separate DOD. There is going to be a joint security posture that is going to support the transition of a soldier, sailor, airman, marine from the Active Duty environment to the veteran environment. So that is of the utmost importance to us.

Mr. Blackburn.

Mr. BLACKBURN. Yes. I share your concerns on cybersecurity. The VA does not have a great track record. I think we have been on the GAO high-risk report as a material weakness for 16 consecutive years, which is a streak that we are not proud of. But I am proud that we have made great strides over the last 2 or 3 years, and we have gotten good feedback from GAO and OIG on that.

I think one of the reasons we have been so vulnerable is having these 130 instances on an antiquated system, so this will help that out. But, in the future, we will be looking, you know, at new emerging technologies, whether it is blockchain or whatever it might be, to get that even more secure.

Mr. VALADAO. I just feel that the transition period is something we need to be very careful with.

So my time is up, and thank you very much.

Mr. DENT. At this time, I would like to recognize the gentleman from Nebraska for 5 minutes, Mr. Fortenberry.

Mr. FORTENBERRY. Gentlemen, good morning.

Mr. Secretary, nice to see you.

ALTERNATIVE WAYS TO ACHIEVE INTEROPERABLE EHR

You have an extensive background in healthcare management, running facilities, being an entrepreneur. If someone told you this was going to take you 10 years before an implementation of an interoperable system in one of your hospitals, you would find that absolutely unacceptable.

Now, this is a big, massive project that a lot of the difficulties, or, put more succinctly, mess, you have inherited, I get that, but this has been going on for a very long time.

So let me just try to simplify this so that I can understand and perhaps we can unpack a lot of this technical language. But I have

about four things I want to get to, including some issues of late in Nebraska.

You have a system now where you are on one screen, you can show DOD records and your records, right? That is interoperability at the moment. This is going to be combined so that one button pulls up everything from a former servicemember's life, right?

Secretary SHULKIN. Yes.

Mr. FORTENBERRY. Okay. Why 10 years?

I very much appreciate what you are saying, that we are getting out of the software business, because why would we build out the expertise in that area when that is not our expertise? You want to deliver care. I get that.

Why 10 years? What do you expect the outcome to be? Are there progress measures along the way so that in another year the system is not going to say, "We have another significant delay, and it is 2 more years."

Let me throw everything out on the table——

Secretary SHULKIN. Sure. Absolutely.

Mr. FORTENBERRY [continuing]. First, and then I would like you to get to it.

We have some information that the VA has always worked with the Indian Health Service to help them with their electronic medical records, but there is some indication that you may desire to move away from that. I would like your comment on that. Because that is some slippage that may cause significant difficulty for another part of government that we would not like to see.

Secretary SHULKIN. Sure.

Mr. FORTENBERRY. Finally, there is a glitch in the outpatient clinic contract in Lincoln. Give me your assessment of that situation. And explain the criteria for site selection, because I think there is some murkiness there that has caused some possible confusion.

Then I have, hopefully, an answer to all of your problems, if we have enough time.

Secretary SHULKIN. Okay. I would like to hear the answer. Are you sure you don't want to start with the answer?

Look, I think the implementation is, frankly, 18 months. From the time we sign the contract till we get our first site up is 18 months, which is consistent with a private-sector practice in terms of from contract to full implementation.

We will begin to, after that first implementation, start shutting down what will be 130 successive implementations after that. So, by the time we reach all of our facilities across the country, which are around 1,600, but 130 different systems control those 1,600, it will be around 8 years after the first 18-month implementation.

Mr. FORTENBERRY. So, after 18 months, what percent of systems will have successful interoperability?

Secretary SHULKIN. Well, we will start with one, and then——

Mr. FORTENBERRY. But what percent of veterans does that represent?

Secretary SHULKIN. Oh. Well, that would be a very small percent of veterans. But what we have is a detailed project implementation timeline, which we would be glad to show you, how we get from one system in 18 months all the way through.

Mr. FORTENBERRY. That is not really necessary. You understand the nature of the question. Obviously, you are going to try something to make sure it works. But the larger number of veterans that is going to actually be served as a priority would seem to me to be a prudent way forward.

Secretary SHULKIN. Yes. The longer we take to implement this, the more costly it is and the greater we think that the risk is to veterans. So we are trying to do this as aggressively as we possibly can.

Mr. FORTENBERRY. Okay.

INDIAN HEALTH SERVICE EHR

My time is running short. I am sorry. Can you, in 30 seconds, address the Indian Health Service question?

Secretary SHULKIN. Yes. The Indian Health Service does use our VistA system. That will remain available. This is an open-source system. We won't withdraw that from them. They may have to look at alternative systems, just as we are, and we would be glad to work with them on that. We have no desire to hold——

Mr. FORTENBERRY. We don't want to put them in a situation where they are having to go out on their own and redesign an entire system.

Secretary SHULKIN. Right. Exactly.

Mr. FORTENBERRY. So anything they can leverage from your experience would be most helpful.

Mr. WINDOM. Can I touch on this?

Secretary SHULKIN. Yes.

Mr. WINDOM. So we have been in communication with Indian Health Services. And we are firmly committed to supporting them——

Mr. FORTENBERRY. Great. Thank you. I am sorry to interrupt. Time is ticking.

LINCOLN, NEBRASKA CLINIC

Secretary SHULKIN. Okay. And Lincoln, Nebraska, we will get back to you on that. But that was a small-business issue, in terms of the award, where we have had to go now back out for contract. We are committed to that contract. It is off-schedule because of small-business issue, but we can get back——

Mr. FORTENBERRY. As we have discussed before, a lot of very creative public-private-public partnerships are on the line here that will provide additional housing and additional development opportunities on a beautiful historic site.

Secretary SHULKIN. Right.

Mr. FORTENBERRY. We just need for this to move, and move quickly, because there is a lot on hold.

Secretary SHULKIN. Yes. I will follow up with you on that.

[The information follows:]

In fiscal year 2014, Congress passed the Veterans Access, Choice, and Accountability Act, which authorized VA to procure 27 Major leases, one of which was an Outpatient Clinic (OPC) in Lincoln, Nebraska. This project will support the VA Nebraska-Western Iowa Health Care System's Omaha VA Medical Center (VAMC). Clinical services currently housed on the existing 60-acre Lincoln campus will be moved to this proposed OPC.

On October 18, 2017, the Department of Veterans Affairs (VA) announced it will start a new, competitive lease procurement process for the Lincoln, Nebraska Outpatient Clinic, which will be initiated in fall 2017.

This decision follows an August 2017 bid protest that an interested party filed with the U.S. Government Accountability Office, regarding VA's prior competitive procurement action.

In that action, the U.S. Small Business Administration determined that the proposed awardee no longer qualified as a small business. Accordingly, VA excluded the protestor from the competition, reviewed the remaining offers, and ultimately determined it was best for VA to cancel that procurement. VA now plans to revise its solicitation to update and adjust its actual leasing requirements. This will bring the project more in line with industry standards, reduce costs proportionately, and provide stronger value to the Government and taxpayers.

VA anticipates release of the new Lincoln Request for Lease Proposals in Spring 2018, with a potential award in CY 2018. VA is committed to delivering a long-term clinical solution that meets the needs of Veterans and their families in the Lincoln, Nebraska area. VA will continue to provide care at the current Lincoln VA clinic during this process.

Mr. FORTENBERRY. Thank you so much.

Mr. DENT. Thank you, Mr. Fortenberry.

Before we move into the closed session, which will happen in moments and members can ask additional questions, I did have two questions that I felt needed to be asked in open session to the Secretary.

ADMINISTRATION COMMITMENT

One is, what is OMB's commitment to this entire project? We noticed that OMB has not submitted a fiscal year 2018 budget amendment as it did for the Department of Defense. I think that is very important we establish in the open session.

Secretary SHULKIN. Yes. As you know, we have been working very closely with OMB, just like we have come to you and asked for your assistance, and they are both aware and supportive of this initiative.

Mr. DENT. And there is one final question.

EHR VULNERABILITY TO POLITICAL CHANGES

Mr. Secretary, you and I have joked that neither of us will be in the jobs we currently hold in 10 years. But, in a serious vein, I am concerned that, without consistent leadership, this expensive project could be derailed or reconfigured, given the long implementation time. We have seen the electronic health record whipsaw back and forth every time a new Secretary of VA or DOD comes to the scene.

Is it a fair concern for the committee that this health record won't be able to withstand changes in political leadership or budgetary shortfalls?

Secretary SHULKIN. Well, first of all, if you commit to stay, then I will consider that too.

But, no, I think that it would be—once we step in this direction—and I think as all of you have really reflected, this is the right thing to do. This is the right thing; it should have been done years ago. I do not believe this is going to be subject to political back-and-forths.

And we are going to set this up in a way that, when we start this, there is the full commitment. And, while anything could happen, I don't believe that this is likely to be derailed.

Mr. DENT. Thank you.

I was going to ask Ms. Lee to ask a question in open session. And then members will have a next round in closed session, so anything you want to ask, you can ask in there.

Ms. Lee.

Ms. LEE. Okay. Thank you very much.

FATE OF EMPLOYEES TRAINED ON VISTA

I just want to find out who is going to maintain this system once the new system is rolled out and fully implemented. And what is going to happen to VA employees maintaining VistA once the Cerner system is rolled out, and will they move over to the new Cerner system?

Secretary SHULKIN. Yes. The basic upkeep and modernization of the new system is going to be done by the Cerner Corporation. That is the whole point of us getting out of the software development system.

Our current employees, we need every one of them. It is very rare to find software engineers who know MUMPS, which is our system, which started back in 1977. But they will—we want them to stay, we need them to stay over this implementation period. And any staff, once we shut down the VistA system, will be utilized as part of our current IT software—part of our infrastructure needs.

Ms. LEE. So no job loss.

Secretary SHULKIN. We do not believe this will be a job loss.

Ms. LEE. Okay.

Thank you, Mr. Chairman, very much.

Mr. DENT. Thank you, Ms. Lee.

At this time, I think our members have had a good opportunity to ask questions about the electronic health record in the public setting. We will now adjourn and move to closed session so that members may discuss with the Secretary issues that could compromise contract negotiations if discussed publicly.

We ask members of the public to leave the room at this time. Associate staff members, committee staff, VA staff, and our court reporter, of course, may stay.

So, with that, we will adjourn and go into closed session.

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