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MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2014

THURSDAY, APRIL 18, 2013

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:43 p.m., in room SD–124, Dirksen Senate Office Building, Hon. Tim Johnson (chairman) presiding.

Present: Senators Johnson, Reed, Udall, Begich, Mikulski, Kirk, Collins, Murkowski, and Hoeven.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. ERIC K. SHINSEKI, SECRETARY OF VETERANS AFFAIRS

ACCOMPANIED BY:

HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH

HON. ALLISON HICKEY, UNDER SECRETARY FOR BENEFITS

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OPENING STATEMENT OF SENATOR TIM JOHNSON

Senator JOHNSON. Good afternoon. This hearing will come to order. We meet today to review the President's fiscal year 2014 budget request for the Department of Veterans Affairs (VA).

Secretary Shinseki, I welcome you and your colleagues, and I thank you for your appearance before this subcommittee.

I'm also very pleased to welcome back my colleague and ranking member, Senator Mark Kirk. Senator Kirk has made great progress in his recovery due, I'm sure, as much to his sheer grit and determination as to his medical team. Senator Kirk has been a strong supporter and partner on this subcommittee, and I look forward to continuing our work on behalf of the Nation's vets.

Mr. Secretary, I'm pleased to see that eliminating the backlog in claims processing is among your top priorities. We must fix this problem once and for all. After fighting for our Nation on the battlefield, our vets simply cannot be subject to months, if not years, of fighting redtape to secure the benefits they have earned.

This subcommittee has provided every time the VA has requested to improve claims processing. I understand the challenges posed by the growing number and complexity of claims.

I understand the challenges of recruiting and training additional claims processors. But despite the VA's best efforts, the situation has grown worse, not better.

Mr. Secretary, I know you share my frustration. I look forward to hearing the VA's way forward to solve this problem sooner rather than later.

I'm also concerned with progress of efforts to integrate the Department of Defense (DOD) and VA health records. It is imperative that the DOD and VA develop an electronic health record system that will allow the seamless exchange of vets' medical records between the two agencies.

The original plan was to develop a single integrated system to serve both agencies. Recently, the agencies changed course and are now pursuing separate systems that can essentially talk to each other.

I certainly support a faster, cheaper way to allow DOD and the VA to share vets' health records, but I'm wary of any change in strategy that might result in the quick surface improvements, but not capture the full range of a patient's health history; in other words, settling for an executive summary instead of a full report.

Mr. Secretary, I look forward to your testimony, and I now ask my ranking member for any opening remarks he cares to make.

Senator Kirk.

STATEMENT OF SENATOR MARK KIRK

Senator KIRK. I'm mad at you for announcing your retirement. You have been an honorary member of my medical recovery team, with your wife and her support to my girlfriend. That has been really something.

Constantly through my medical recovery, I was asking, "What can Tim do?" and meet that area. It was always great to think about you back here rocking and rolling.

I will say, Mr. Secretary, very good to see you here today. I want to thank you. And I've thanked you over and over again for shepherding the Stryker vehicle through the U.S. Army. As a reservist in Afghanistan, I had an opportunity to use it. I will say, in the small time that I had in the vehicle, we did have a little problem with the coffeemaker. The espresso setting wasn't quite fully functional.

Let me just continue slightly. I want to continue on the unified record issue. Our vision is to have someone join the Navy and then retire, and the record all passes straight into the VA. That is what we were hoping. My understanding is we have a choice between two software systems—one in the VA called VistA, which handles the VA systems.

And the one thing I want to commend you on, Mr. Secretary, is you have released the code to what you own, is what I understand. My hope is that someday we would go with, for lack of a better term, we would have an android-kind of culture, an explosion of apps that the private sector can develop on the VistA or AHLTA backbone now that it's open source, and we have an explosion of

innovation in health records management of advantage to veterans and sailors everywhere.

PREPARED STATEMENT

Just a last thing to say, I have been in touch with Chairman Culberson to eventually bring an end to this combination process. I think at some date prior to the big markup of this subcommittee, that we should pick either VistA or AHLTA as the backbone, so just VA or DOD wins and so the taxpayer only pays for one software management system.

[The statement follows:]

PREPARED STATEMENT OF SENATOR MARK KIRK

Thank you, Mr. Chairman. I'm pleased to be back here today as ranking member of this subcommittee. I would like to join you in welcoming Secretary Shinseki and our other witnesses and guests to discuss the President's 2014 budget request for the Department of Veterans Affairs (VA).

OVERVIEW

The 2014 request for the Department of Veterans Affairs proposes $149.6 billion, which consists of $63.5 billion in discretionary funding, which is 4 percent above the 2013 enacted level, and $86.1 billion in mandatory funding, which is 18 percent above the 2013 enacted level. In addition, the Department is requesting $55.6 billion in advance appropriations for the medical care accounts in 2015. That is a total of $205 billion before us today—a tremendous amount of money—and in a time of record-high deficits and debt, my priority and the priority of this subcommittee is not only to give our veterans the very best care this Nation can provide, but also to analyze this budget to ensure we are spending our taxpayers' dollars wisely, without excess or redundancy.

Mr. Chairman, the VA under the leadership of Secretary Shinseki is doing a great job taking care of our Nation's veterans and I would like to thank him for his hard work and dedication. There are many issues we need to discuss today but I want to focus on two issues that will play a significant role in the lives of all veterans: electronic health record and claims processing.

INTEGRATED ELECTRONIC HEALTH RECORD (IEHR)

Earlier this year, we learned the VA and DOD's decision to create a single, common, joint, integrated Electronic Health Record (iEHR) has changed, and now the two Departments are no longer planning to operate on one core system—instead, the VA will stay with a modernized VISTA system while the Department of Defense will select another system. This was due, we were told, to the exorbitant cost creep associated with the creation of a truly joint record. Secretary Shinseki, I hope to hear details today about your discussions with the new Secretary of Defense, and the plan you have to move forward on a joint, open-architecture, non-proprietary designed electronic health record system. Our men and women in uniform need to trust their health record will follow them seamlessly from the day they raise their right hand through their time as a proud veteran of this Nation and we will work with you and your Department to make this a reality.

CLAIMS PROCESSING

Mr. Secretary, you have stated numerous times one of your highest priorities was to eliminate the disability claims backlog by 2015. You also stated the Veterans Benefits Management System and the Veterans Relationship Management initiative would help your Department make significant headway in reducing the backlog, yet today, 70 percent of claims are older than 125 days and the average wait time is nearly a year. In Chicago, the average wait time actually increased by 141 days in 2012 to an astonishing 431 day wait. I look forward to hearing details from you today on how the Department will meet or beat the deadline you set for a reduction in the backlog. I know you are working hard on this process, but we desperately need results.

CLOSING

Mr. Chairman, this subcommittee has always worked hard together to provide the Department with the all the resources it needs. I look forward to working with you to make sure we give our veterans all they have earned.

Thank you, Mr. Chairman.

Senator JOHNSON. Thank you, Senator Kirk.

Again, Mr. Secretary, welcome and thank you for appearing before this subcommittee. I understand that yours will be the only opening statement. Your full statement will be included in the record, so please feel free to summarize your remarks.

Please proceed.

SUMMARY STATEMENT OF HON. ERIC K. SHINSEKI

Secretary SHINSEKI. Well, thank you very much, Chairman Johnson, Ranking Member Kirk—I understand Chairwoman Mikulski will be attending at some point; I acknowledge that—other distinguished members of the subcommittee.

Thank you for this opportunity to present the President's 2014 budget and 2015 advanced appropriations request for VA. We deeply value your partnership and support in providing the resources needed to ensure quality care and services for veterans. That's been true for the 4 years that I've served in this capacity.

Let me also acknowledge other partners who are here today, our veterans service organizations whose insights and support make us much better at our mission of caring for veterans, their families, and survivors.

Mr. Chairman, if I could just take a few seconds here to introduce the other members of my panel. Seated to my far left and to your right, Steph Warren is our Acting Assistant Secretary for Information and Technology. To my left is Todd Grams, our Chief Financial Officer. To my right is Dr. Randy Petzel, Under Secretary for Health, and then Allison Hickey, Under Secretary for Benefits. On the far right is Mr. Steve Muro, our Under Secretary for Memorial Affairs.

Mr. Chairman, thank you for accepting my written record.

Let me just say very quickly, the 2014 budget and the 2015 advanced appropriations requests demonstrate the President's steadfast commitment to our Nation's veterans. I thank the members for your resolute commitment to veterans as well and seek your support for these requests.

The latest generation of veterans is enrolling in VA at a higher rate than previous generations; 62 percent of those who deployed in support of operations in Iraq and Afghanistan have used at least one VA benefit or service.

VA's requirements are expected to continue growing for years to come. Our plans and resourcing must be robust enough to care for them all. What you'll see in our plan is that look to the future.

The President's 2014 budget for VA requests $152.7 billion, with $66.5 billion in discretionary funding, and $86.1 billion in mandatory funding. An increase of $2.7 billion in discretionary funding equates to about a 4.3-percent increase above the 2013 level.

This is a strong budget, which enables us to continue building momentum for delivering the three major goals we set for ourselves 4 years ago. One, to increase veterans' access to VA's benefits and

services, and we have done that. Two, eliminate the disability claims backlog in 2015, and we've put together a robust plan that's funded in order to accomplish that. Finally three, end veterans' homelessness in 2015 as well.

These were bold and ambitious goals 4 years ago, and they remain bold and ambitious goals today, because veterans deserve a VA that advocates for them and then puts the resources behind the promises it has made.

When it comes to access, of the roughly 22 million living veterans in the country today, more than 11 million now receive at least one benefit or service from VA, and that's an increase of over 1 million veterans in the last 4 years. We have achieved this by opening new facilities, renovating others, increasing investments in telehealth and telemedicine, sending mobile clinics and vet centers to remote areas where veterans live, and then using every means available, including social media, to connect more veterans to VA. Increasing access has been a success story for us and our numbers show it.

Backlog—too many veterans wait too long to receive the benefits they've earned and they deserve. We know this is unacceptable and no one wants to turn this around anymore than I do or Secretary Hickey, or the workers at the Veterans Benefits Administration (VBA); 52 percent of whom are veterans themselves. We are resolved to eliminate the claims backlog in 2015 when claims will be processed in 125 days or less at a 98 percent accuracy level.

Our efforts mandate investments in VBA's people, processes, and technology.

As far as people are concerned, more than 2,300 claims processors have completed training to improve the quality and productivity of their decisions. More are being trained today, and VBA's new employees now complete more claims per day than their predecessors.

In terms of processes, we use a disability benefits questionnaire—we call it a DBQ—an online form for submitting medical evidence. And that has dropped the average processing times of medical exams and increased accuracy.

There are now three lanes for processing claims: an express lane for those that will predictably take less time; a special operations lane, if you will, for unusual cases or those requiring special handling; and a core lane for probably the majority of claims that will be handled.

Technology is critical to this discussion. It is critical to ending the backlog. Our paperless processing system, and it is called Veterans Benefits Management System (VBMS) will be faster, improve access, drive automation, and reduce variance.

Thirty-six regional offices out of our 56 regional offices all now have VBMS, 36 of 56. We had planned to have this fielding completed by the end of this year, December. We're going to beat that milestone. We're pulling fielding to the left as far as we can. Those are all the adjustments that are underway.

In terms of homelessness, the last of our three priorities is to end veterans homelessness in 2015. Since 2009, we've reduced the estimated number of homeless veterans by 17 percent. The latest available estimate from January 2012 is 62,600 veterans remain homeless on the streets. There's more work to be done here, but

we've mobilized a national program that reaches into communities all across this country.

The rescue phase of this is intended to end in 2015. Continuing long beyond that, we expect that we're going to have a prevention of veterans homelessness program that will be the follow-on main effort, preventing veterans from ending up on the streets.

PREPARED STATEMENT

Mr. Chairman, we're committed to the responsible use of the resources Congress provides. Again, thank you for this opportunity to appear here today, and for your support of veterans. We look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF HON. ERIC K. SHINSEKI

Chairman Johnson, Ranking Member Kirk, distinguished members of the Senate Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs and Related Agencies: Thank you for the opportunity to present the President's 2014 budget and 2015 advance appropriations requests for the Department of Veterans Affairs (VA). This budget continues the President's historic initiatives and strong budgetary support and will have a positive impact on the lives of Veterans, their families, and survivors. We value the unwavering support of the Congress in providing the resources and legislative authorities needed to care for our Veterans and recognize the sacrifices they have made for our Nation.

The current generation of Veterans will help to grow our middle class and provide a return on the country's investments in them. The President believes in Veterans and their families, believes in providing them the care and benefits they've earned, and knows that by their service, they and their families add strength to our Nation.

Twenty-two million living Americans today have distinguished themselves by their service in uniform. After a decade of war, many Servicemembers are returning and making the transition to Veterans status. The President's 2014 budget for VA requests $152.7 billion—comprised of $66.5 billion in discretionary funds, including medical care collections, and $86.1 billion in mandatory funds. The discretionary request reflects an increase of $2.7 billion, 4.3 percent above the 2013 level. Our 2014 budget will allow VA to operate the largest integrated healthcare system in the country, with more than 9.0 million Veterans enrolled to receive healthcare; the ninth largest life insurance provider, covering both Active Duty members as well as enrolled Veterans; an education assistance program serving over 1 million students; a home mortgage service that guarantees over 1.5 million Veterans' home loans with the lowest foreclosure rate in the Nation; and the largest National Cemetery System that leads the Nation as a high-performing organization, with projections to inter about 121,000 Veterans and family members in 2014.

PRIORITY GOALS

Over the next few years, more than 1 million Veterans will leave military service and transition to civilian life. VA must be ready to care for them and their families. Our data shows that the newest of our country's Veterans are relying on VA at unprecedented levels. Through January 31, 2012, of the approximately 1.58 million Veterans who returned from Operations Enduring Freedom, Iraqi Freedom, and New Dawn, at least 62 percent have used some VA benefit or service.

VA's top three priorities—increase access to VA benefits and services; eliminate the disability compensation claims backlog in in 2015; and end Veterans homelessness, also in 2015—anticipate these changes and identify the performance levels required to meet emerging needs. These ambitious goals will take steady focus and determination to see them through. As we enter the critical funding year for VA's priority goals, this 2014 budget builds upon our multiyear effort to position the Department through effective, efficient, and accountable programming and budget execution for delivering claims and homeless priority goals.

STEWARDSHIP OF RESOURCES

Safeguarding the resources—people, money, time—entrusted to us by the Congress, managing them effectively, and deploying them judiciously, is a fundamental duty. Effective stewardship requires an unflagging commitment to use resources ef-

ficiently with clear accounting rules and procedures, to safeguard, train, motivate, and hold our workforce accountable, and to assure the effective use of time in serving Veterans on behalf of the American people. Striving for excellence in stewardship of resources is a daily priority. At VA, we are ever attentive to areas in which we need to improve our operations, and are committed to taking swift corrective action to eliminate any financial management practice that does not deliver value for Veterans.

VA's stewardship of resources begins at headquarters. Recognizing the very difficult fiscal constraints facing our country, the 2014 request includes a 5.0 percent reduction in the departmental administration budget from the 2013 enacted level. This reduction follows a headquarters freeze in the 2013 President's budget—a 2-year commitment.

Recent audits of the Department's financial statements have certified VA's success in remediating all three of our remaining material weaknesses in financial management, which had been carried forward for over a decade. In terms of internal controls and fiscal integrity, this was a major accomplishment. In the past 4 years, we have also dramatically reduced the number of significant financial deficiencies from 16-to-1.

At VA, we believe that part of being responsible stewards is shutting down Information Technology (IT) projects that are no longer performing. Developed by our Office of Information and Technology, the Project Management Accountability System (PMAS) requires IT projects to establish milestones to deliver new functionality to its customers every 6 months. Now entering its third year, PMAS continues to instill accountability and discipline in our IT organization. Through PMAS, the cumulative, on-time delivery of IT functionality since its inception is 82 percent, a rate unheard of in the industry where, by contrast, the average is 42 percent. By implementing PMAS, we have achieved at least $200 million in cost avoidance by shutting down or improving the management of 15 projects.

Through the effective management of our acquisition resources, VA has achieved savings of over $200 million by participating in Federal strategic sourcing programs and establishing innovative IT acquisition contracts. In 2012, VA led the civilian agencies in contracting with Service-Disabled Veteran-Owned Small Businesses, which, at $3.4 billion, accounted for 19.3 percent of all VA procurement awards. In addition, we have reduced interest penalties for late payments by 19 percent (from $47 to $38 per million) over the past 4 years.

Finally, VA's stewardship achieved savings in several other areas across the Department. The National Cemetery Administration (NCA) assumed responsibility in 2009 for processing First Notices of Death to terminate compensation benefits to deceased Veterans. Since taking on this responsibility, NCA has advised families of the burial benefits available to them, assisted in averting overpayments of some $142 million in benefit payments and, thereby, helped survivors avoid possible collections. In addition, we implemented the use of Medicare pricing methodologies at the Veterans Health Administration (VHA) to pay for fee-basis services, resulting in savings of over $528 million since 2012 without negatively impacting Veteran care and with improved consistency in billing and payment.

TECHNOLOGY

To serve Veterans as well as they have served us, we are working on delivering a 21st century VA that provides medical care, benefits, and services through a digital infrastructure. Technology is integrated with everything we do for Veterans. Our hospitals use information technology to properly and accurately distribute and deliver prescriptions/medications to patients, track lab tests, process MRI and X-ray imaging, coordinate consults, and store medical records. VA IT systems supported over 1,300 VA points of healthcare in 2012: 152 medical centers, 107 domiciliary rehabilitation treatment programs, 821 community-based outpatient clinics, 300 Vet Centers, 6 independent outpatient clinics, 11 mobile outpatient clinics, and 70 mobile Vet Centers. Technology supports Veterans' education and disability claims processing, claims payments, home loans, insurance, and memorial services. Our IT infrastructure consists of telephone lines, data networks, servers, workstations, printers, cell phones, and mobile applications.

No Veteran should have to wait months or years for the benefits that they have earned. We will eliminate the disability claims backlog in 2015; technology is the critical component for achieving our goal. VA is deploying technology solutions to improve access, drive automation, reduce variance, and enable faster and more efficient operations. Building on the resources Congress has provided in recent years to expand our claims processing capacity, the 2014 budget requests $291 million for technology to eliminate the claims backlog—$155 million in Veterans Benefits Man-

agement System (VBMS) for our new paperless processing system, and $136 million in the Veterans Benefits Administration (VBA) to support a Veterans Claims Intake Program, our new online application system that will allow for the conversion of paper to digital images for our new paperless processing system, the Veterans Benefits Management System (VBMS). Without these resources, VA will be unable to meet its goal to eliminate the disability claims backlog in 2015.

Information Technology

At VA, advances in technology—and the adoption of and reliance on IT in our daily commercial life—have been dramatic. Technology is integral to providing high-quality healthcare and benefits. The 2014 budget requests $3.683 billion for IT, an increase of $359 million from the President's 2013 budget, reflecting the critical role technology plays in VA's daily work in serving and caring for Veterans and their families. Of the total request, $2.2 billion will support the operation and maintenance of our digital infrastructure and $495 million is for IT development modernization and enhancement projects.

The 2014 budget includes $32.8 million for development of VBMS, our new paperless processing system that enables VA to move from its current paper-based process to a digital operating environment that improves access, drives automation, reduces variance, and enables faster, more efficient operations. As we increase claims examiners' use of VBMS version 4.2 to process rating disability claims, our major focus is on system performance, as we tune the system to be responsive and effective. VA will complete the rollout of VBMS in June 2013.

In addition, the 2014 budget includes $120 million for development of the Veterans Relationship Management (VRM) initiative, which enhances Veterans' access to comprehensive VA services and benefits, especially in the delivery of compensation and pension claims processing. The program gives Veterans secure, personalized access to benefits and information and allows a timely response to their inquiries. Recently, VRM released Veterans Online Application Direct Connect (VDC), which enables Veterans to apply for VBA benefits by answering guided interview questions through the security of the eBenefits portal. Claims filed through eBenefits use VDC to load information and data directly into VBMS.

The Virtual Lifetime Electronic Record (VLER) is an overarching program which aims to share health, benefits, and administrative information, including personnel records and military history records, among DOD, VA, SSA, private healthcare providers, and other Federal, State, and local government partners. eBenefits is already reaching 2 million Veterans and Servicemembers and 1 million active users with BlueButton. The 2014 budget requests $15.4 million for VLER to develop and support these functions as well as the Warrior Support Veterans Tracking Application; the Disability Benefits Questionnaires; a VA–DOD joint health information sharing project known as Bidirectional Health Information Exchange; and a storage interface known as Clinical Data Repository/Health Data Repository. All of these efforts are designed to enable the sharing of health, military personnel and personal information among VA, other Federal agencies, Veteran Service Organizations and private healthcare providers to expedite the award and processing of disability claims and other services such as education, training and job placement.

ELIMINATING THE CLAIMS BACKLOG

Too many Veterans wait too long to receive benefits they have earned. This is unacceptable. Today's claims backlog is the result of several factors, including: increased demand; over a decade of war with many Veterans returning with more severe, complex injuries; decisions on agent orange, gulf war, and combat PTSD presumptions; and, successful outreach to Veterans informing them of their benefits. These facts, in no way, diminish the urgency that we all feel at VA to fix this problem which has been decades in the making. VA remains focused on eliminating the disability claims backlog in 2015 and processing all claims within 125 days at a 98-percent accuracy level.

To deliver this goal, the Veterans Benefits Administration (VBA) is implementing a comprehensive transformation plan based on more than 40 targeted initiatives to boost productivity by over the next several years. However, as VBA transforms its people, processes, and technologies, its claims demand is expected to exceed on million annually. From 2010 through 2012, for the first time in its history, VBA processed more than 1 million claims in three consecutive years. In 2013, VBA expects to receive another million claims and similar levels of demand are anticipated in 2014. This is driven by successful outreach, claims growth not previously captured in VBA's baseline, and new requirements. Included are mandatory Servicemember participation in VOW/VEI benefits briefings and an expected increase upon successful completion of a transition assistance program, revamped by the President as

Transition: Goals, Plan, Success (GPS). As more than 1 million troops leave service over the next 5 years, we expect our claims workload to continue to rise. In addition, VBA is experiencing an unprecedented workload growth arising from the number and complexity of medical conditions in Veterans' compensation claims. The average number of claimed conditions for our recently separated Servicemembers is now in the 12 to 16 range—roughly five times the number of disabilities claimed by Veterans of earlier eras. While the increase in compensation applications presents challenges, it is also an indication that we are being successful in our efforts to expand access to VA benefits.

Investments in transformation of our people, processes, and technologies are already paying off in terms of improved performance. For example:

—*People.*—More than 2,100 claims processors have completed Challenge Training, which improves the quality and productivity of VBA compensation claims decision makers. As a result of Challenge Training, VBA's new employees complete more claims per day than their predecessors—with a 30-percent increase in accuracy.

VBA's new standardized organizational model incorporates a case-management approach to claims processing that organizes its workforce into cross-functional teams that work together on one of three segmented lanes: express, special operations, or core. Claims that predictably can take less time will flow through an express lane (30 percent); those taking more time or requiring special handling will flow through a special operations lane (10 percent); and the rest of the claims flow through the core lane (60 percent). Initially planned for deployment throughout 2013, VBA accelerated the implementation of the new organizational model by 9 months due to early indications of its positive impact on performance.

VBA instituted Quality Review Teams (QRTs) in 2012 to improve employee training and accuracy while decreasing rework time. QRTs focus on improving performance on the most common sources of error in the claims processing cycle. Today, for example, QRTs are focused on the process by which proper physical examinations are ordered; incorrect or insufficient exams previously accounted for 30 percent of VBA's error rate. As a result of this focus, VBA has seen a 23-percent improvement in this area.

—*Process.*—Disability Benefits Questionnaires (DBQs) are online forms used by non-VA physicians to submit medical evidence. Use of DBQs has improved timeliness and accuracy of VHA-provided exams—average processing time improved by 6 days from June 2011 to October 2012 (from 32 to 26 days).

Fully developed claims (FDCs) are critical to reducing "wait time" and "rework." FDCs include all DOD service medical and personnel records, including entrance and exit exams, applicable DBQs, any private medical records, and a fully completed claim form. Today, VBA receives 4.5 percent of claims in fully developed form and completes them in 117 days, while a regular claim takes 262 days to process. Fulfilling the Veterans Claims Assistance Act, to search for potential evidence, is the greatest portion of the current 262-day process. The Veterans Benefit Act of 2003 allows Veterans up to 365 days, from the date of VA notice for additional information or evidence, to provide documentation. Of the 262 days to complete a regular claim, approximately 145 days are spent waiting for potential evidence to qualify the application as a fully developed claim.

VBA built new decision-support tools to make our employees more efficient and their decisions more consistent and accurate. Rules-based calculators provide suggested evaluations for certain conditions using objective data and rules-based functionality. The Evaluation Builder uses a series of check boxes that are associated with the Veteran's symptoms to help determine the proper diagnostic code of over 800 codes, as well as the appropriate level of compensation based on the Veteran's symptoms.

—*Technology.*—The centerpiece of VBA's transformation plan is VBMS—a new paperless electronic claims processing system that employs rules-based technology to improve decision speed and accuracy. For our Veterans, VBMS will mean faster, higher quality, and more consistent decisions on claims. Our strategy includes active stakeholder participation (Veterans Service Officers, State Departments of Veterans Affairs, County Veterans Service Officers, and Department of Defense) to provide digital electronic files and claims pre-scanned through online claims submission via the eBenefits Web portal.

VBA recently established the Veterans Claims Intake Program (VCIP). This program will streamline processes for receiving records and data into VBMS and other VBA systems. Scanning operations and the transfer of Veteran data into VBMS are primary intake capabilities that are managed by VCIP. As

VBMS is deployed to additional regional offices, document scanning becomes increasingly important as the main mechanism for transitioning from paper-based claim folders to the new electronic environment.

There are other ways that VA is working to eliminate the claims backlog. VHA has implemented multiple initiatives to expedite timely and efficient delivery of medical evidence needed to process a disability claim by VBA. As a result, timeliness improved by nearly one-third, from an average of 38 days in January 2011 to 26 days in October 2012. Recently, VA launched Acceptable Clinical Evidence (ACE), an initiative that allows clinicians to review existing medical evidence and determine whether they can use that evidence to complete a DBQ without requiring the Veteran to report for an in-person examination. This initiative was developed by both VHA and VBA in a joint effort to provide a Veteran-centric approach for disability examinations. Use of the ACE process opens the possibility of doing assessments without an in-person examination when there is sufficient information in the record.

Another way to eliminate the claims backlog is by working closely with the DOD. The Integrated Disability Evaluation System (IDES) is a collaborative system to make disability evaluations seamless, simple, fast and fair. If the Servicemember is found medically unfit for duty, the IDES gives them a proposed VA disability rating before they leave the service. These ratings are normally based on VA examinations that are conducted using required IDES examination templates. In fiscal year 2012, IDES participants were notified of VA benefit entitlement in an average of 54 days after discharge. This reflects an improvement from 67 days in May 2012 to 49 days in September 2012.

The Benefits Delivery at Discharge (BDD) and Quick Start programs are two other collaborations for Servicemembers to file claims for service-connected disabilities. This can be done from 180 to 60 days prior to separation or retirement. BDD claims are accepted at every VA Regional Office and at intake sites on military installations in the United States, and at two intake site locations overseas. In 2012, BDD received more than 30,300 claims and completed 24,944—a 14-percent increase over 2011's productivity (21,657). During this same period of time Quick Start decreased their rating inventory by over 44 percent.

EXPANDING ACCESS TO BENEFITS AND SERVICES

VA remains committed to ensuring that Veterans are not only aware of the benefits and services that they are entitled to, but that they are able to access them. We are improving access to VA services by opening new or improved facilities closer to where Veterans live. Since 2009, we have added 57 community-based outpatient clinics (CBOCs), for a total of 840 CBOCs through 2013, and increased the number of mobile outpatient clinics and mobile Vet Centers, serving rural Veterans, to 81. Last August, we opened a state-of-the-art medical center in Las Vegas, the first new VAMC in 17 years. The 2014 medical care budget request includes $799 million to open new and renovated healthcare facilities and includes the authorization request for 28 new and replacement medical leases to increase Veteran access to services.

Today, access is much more than the ability to walk into a VA medical facility; it also includes technology, and programs, as well as, facilities. Expanding access includes taking the facility to the Veteran—be it virtually through telehealth, by sending Mobile Vet Centers to rural areas where services are scarce, or by using social media sites like Facebook, Twitter, and YouTube to connect Veterans to VA benefits and facilities. Telehealth is a major breakthrough in healthcare delivery in 21st century medicine, and is particularly important for Veterans who live in rural and remote areas. The 2014 budget requests $460 million for telehealth, an increase of $388 million, or 542 percent, since 2009.

As more Veterans access our healthcare services, we recognize their unique needs and the needs of their families—many have been affected by multiple, lengthy deployments. VA provides a comprehensive system of high-quality mental health treatment and services to Veterans. We are using many tools to recruit and retain our large mental healthcare workforce to better serve Veterans by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capabilities. In response to increased demand over the last 4 years, VA has enhanced its capacity to deliver needed mental health services and to improve the system of care so that Veterans can more readily access them. Since 2006, the number of Veterans receiving specialized mental health treatment has risen each year, from over 927,000 to more than 1.3 million in 2012, partly due to proactive screening. Outpatient visits have increased from 14 million in 2009 to over 17 million in 2012. VA believes that mental healthcare must constantly evolve and improve as new knowledge becomes available through research.

The 2014 budget includes $168.5 million for the Veterans Relationship Management (VRM) initiative, which is fundamentally transforming Veterans' access to VA benefits and services by empowering VA clients with new self-service tools. VA has already made major strides under this initiative. Most recently, in November 2012, VRM added new features to eBenefits, a Web application that allows Veterans to access their VA benefits and submit some claims online. Veterans can now enroll in and manage their insurance policies, select reserve retirement benefits, and browse the Veterans Benefits Handbook from the eBenefits Web site. With the help of Google mapping services, the update also enables Veterans to find VA representatives in their area and where they are located. Since its inception in 2009, eBenefits has added more than 45 features allowing Veterans easier, quicker, and more convenient access to their VA benefits and personal information.

VBA has aggressively promoted eBenefits and the ease of enrolling into the system. We currently have over 2.5 million registered eBenefits users. Users can check the status of claims or appeals, review VA payment history, obtain military documents, and perform numerous other benefit actions through eBenefits. The Stakeholder Enterprise Portal (SEP) is a secure Web-based access point for VA's business partners. This electronic portal provides the ability for VSOs and other external VA business partners to represent Veterans quickly and efficiently.

VA also continues to increase access to burial services for Veterans and their families through the largest expansion of its National Cemetery System since the Civil War. At present, approximately 90 percent of the Veteran population—about 20 million Veterans—has access to a burial option in a national, State, or tribal Veterans cemetery within 75 miles of their homes. In 2004, only 75 percent of Veterans had such access. This dramatic increase is the result of a comprehensive strategic planning process that results in the most efficient use of resources to reach the greatest number of Veterans.

ENDING VETERAN HOMELESSNESS

The last of our three priority goals is to end homelessness among Veterans in 2015. Since 2009, we have reduced the estimated number of homeless Veterans by more than 17 percent. The January 2012 Point-In-Time estimate, the latest available, is 62,619. We have also created a National Homeless Veterans Registry to track our known homeless and at-risk populations closely to ensure resources end up where they are needed. In 2012, over 240,000 homeless or at-risk Veterans accessed benefits or services through VA and 96,681 homeless or at-risk Veterans were assessed by VHA's homeless programs. Over 31,000 homeless and at-risk Veterans and their families obtained permanent housing through VA specialized homeless programs.

In the 2014 budget, VA is requesting $1.393 billion for programs to assist homeless Veterans, through programs such as Department of Housing and Urban Development–VA Supportive Housing (HUD–VASH), Grant and Per Diem, Homeless Registry, and Health Care for Homeless Veterans. This represents an increase of $41 million, or 3 percent over the 2013 enacted level. This budget will support our long-range plan to end Veteran homelessness by emphasizing rescue and prevention—rescue for those who are homeless today, and prevention for those at risk of homelessness.

Our prevention strategy includes close partnerships with some 150 community nonprofits through the Supportive Services for Veteran Families (SSVF) program; SSVF grants promote housing stability among homeless and at-risk Veterans and their families. The grants can have an immediate impact, helping lift Veterans out of homelessness or providing aid in emergency situations that put Veterans and their families at risk of homelessness. In 2012, we awarded $100 million in Supportive Service grants to help Veterans and families avoid life on the streets. We are currently reviewing proposals for the $300 million in grants we will distribute later this year. In 2012, SSVF resources directly helped approximately 21,000 Veterans and over 35,000 household members, including nearly 9,000 children. This year's grants will help up to 70,000 Veterans and family members avoid homelessness. The 2014 budget includes $300 million for SSVF.

To increase homeless Veterans' access to benefits, care, and services, VA established the National Call Center for Homeless Veterans (NCCHV). The NCCHV provides homeless Veterans and Veterans at-risk for homelessness free, 24/7 access to trained counselors. The call center is intended to assist homeless Veterans and their families, VA medical centers, Federal, State, and local partners, community agencies, service providers, and others in the community. Family members and non-VA providers who call on behalf of homeless Veterans are provided with information on VA homeless programs and services. In 2012, the National Call Center for Homeless

Veterans received 80,558 calls (123-percent increase) and the center made 50,608 referrals to VA medical centers (133-percent increase).

VA's Homeless Patient Aligned Care Teams (H-PACTs) program provides a coordinated "medical home" specifically tailored to the needs of homeless Veterans. The program integrates clinical care with delivery of social services and enhanced access and community coordination. Implementation of this model is expected to address health disparity and equity issues facing the homeless population. Expected program outcomes include reduced emergency department use and hospitalizations, improved chronic disease management, and improved "housing readiness" with fewer Veterans returning to homelessness once housed.

During 2012, 119,878 unique homeless Veterans were served by the Health Care for Homeless Veterans Program (HCHV), an increase of more than 21 percent from 2011. At more than 135 sites, HCHV offers outreach, exams, treatment, referrals, and case management to Veterans who are homeless and dealing with mental health issues, including substance use. Initially serving as a mechanism to contract with providers for community-based residential treatment for homeless Veterans, many HCHV programs now serve as the hub for myriad housing and other services that provide VA with a way to outreach and assist homeless Veterans by offering them entry to VA medical care.

VA's Homeless Veterans Apprenticeship Program was established in 2012—a 1-year paid employment training program for Veterans who are homeless or at risk of homelessness. This program created paid employment positions as Cemetery Caretakers at 5 of our 131 National Cemeteries. The initial class of 21 homeless Veterans is simultaneously enrolled in VHA's Homeless Veterans Supported Employment program. Apprentices who successfully complete 12 months of competency-based training will be offered permanent full-time employment at a National Cemetery. Successful participants will receive a Certificate of Competency which can also be used to support employment applications in the private sector.

Another avenue of assistance is through Veterans Treatment Courts, which were developed to avoid unnecessary incarceration of Veterans who have developed mental health problems. The goal of Veterans Treatment Courts is to divert those with mental health issues and homelessness from the traditional justice system and to give them treatment and tools for rehabilitation and readjustment. While each Veterans Treatment Court is part of the local community's justice system, they form close working partnerships with VA and Veterans' organizations. As of early 2012 there are 88 Courts.

The Veterans Justice Outreach (VJO) program exists to connect these justice-involved Veterans with the treatment and other services that can help prevent homelessness and facilitate recovery, whether or not they live in a community that has a Veterans Treatment Court. Each VA Medical Center has at least one designated justice outreach specialist who functions as a link between VA, Veterans, and the local justice system. Although VA cannot treat Veterans while they are incarcerated, these specialists provide outreach, assessment and linkage to VA and community treatment, and other services to both incarcerated Veterans and justice-involved Veterans who have not been incarcerated.

MULTIYEAR PLAN FOR MEDICAL CARE BUDGET

Under the Veterans Health Care Budget Reform and Transparency Act of 2009, which we are grateful to Congress for passing; VA submits its medical care budget that includes an advance appropriations request in each budget submission. The legislation requires VA to plan its medical care budget using a multiyear approach. This policy ensures that VA requirements are reviewed and updated based on the most recent data available and actual program experience.

The 2014 budget request for VA medical care appropriations is $54.6 billion, an increase of 3.7 percent over the 2013 enacted level of $52.7 billion. The request is an increase of $157.5 million above the enacted 2014 advance appropriations level. Based on updated 2014 estimates largely derived from the Enrollee Health Care Projection Model, the requested amount would allow VA to increase funding in programs to eliminate Veteran homelessness; continue implementation of the Caregivers and Veterans Omnibus Health Services Act; fulfill multiple responsibilities under the Affordable Care Act; provide for activation requirements for new or replacement medical facilities; and invest in strategic initiatives to improve the quality and accessibility of VA healthcare programs. Our multiyear budget plan assumes that VHA will carry over negligible unobligated balances from 2013 into 2014—consistent with the 2013 budget submitted to Congress.

The 2015 request for medical care advance appropriations is $55.6 billion, an increase of $1.1 billion, or 1.9 percent, over the 2014 budget request. Medical care

funding levels for 2015, including funding for activations, non-recurring maintenance, and initiatives, will be revisited during the 2015 budget process, and could be revised to reflect updated information on known funding requirements and unobligated balances.

MEDICAL CARE PROGRAM

The 2014 budget of $57.7 billion, including collections, provides for healthcare services to treat over 6.5 million unique patients, an increase of 1.3 percent over the 2013 estimate. Of those unique patients, 4.5 million Veterans are in Priority Groups 1–6, an increase of more than 71,000 or 1.6 percent. Additionally, VA anticipates treating over 674,000 Veterans from the conflicts in Iraq and Afghanistan, an increase of over 67,000 patients, or 11.1 percent, over the 2013 level. VA also provides medical care to non-Veterans through programs such the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and the Spina Bifida Health Care Program; this population is expected to increase by over 17,000 patients, 2.6 percent, during the same time period.

The 2014 budget proposes to extend the Administration's current policy to freeze Veterans' pharmacy co-payments at the 2012 rates, until January 2015. Under this policy, which will be implemented in a future rulemaking, co-payments will continue at $8 for Veterans in Priority Groups 2 through 6 and at $9 for Priority Groups 7 through 8.

The 2014 budget requests $47 million to provide healthcare for Veterans who were potentially exposed to contaminated drinking water at Camp Lejeune as required by the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, enacted last August. Since VA began implementation of the law and in January 2013, 1,400 Veterans have contacted us concerning Camp Lejeune. Of these, roughly 1,100 were already enrolled in VA healthcare. Veterans who are eligible for care under the Camp Lejeune authority, regardless of current enrollment status with VA, will not be charged a co-payment for healthcare related to the 15 illnesses or conditions recognized, nor will a third-party insurance company be billed for these services. In 2015, VA expects to start treating family members as authorized under the law and has included $25 million for this purpose within the 2015 advance appropriations request. VA continues a robust outreach campaign to these Veterans and family members while we press forward with implementing this complex new law.

Mental Healthcare and Suicide Prevention

At VA, we have the opportunity and the responsibility to anticipate the needs of returning Veterans. Mental healthcare at VA is a system of comprehensive treatments and services to meet the individual mental health needs of Veterans. VA is expanding mental health programs and is integrating mental health services with primary and specialty care to provide better coordinated care for our Veteran patients. Our 2014 budget provides nearly $7.0 billion for mental healthcare, an increase of $469 million, or 7.2 percent, over 2013. Since 2009, VA has increased funding for mental health services by 56.9 percent. VA provided mental health services to 1,391,523 patients in 2012, 58,000 more than in 2011.

To serve the growing number of Veterans seeking mental healthcare, VA has deployed significant resources and is increasing the number of staff in support of mental health services. Consistent with the President's August 31, 2012, Executive order, VHA is on target to complete the goal of hiring 1,600 additional mental health clinical providers and 300 administrative support staff by June 30, 2013, to meet the growing demand for mental health services. In addition, as part of VA's efforts to implement the Caregivers and Veterans Omnibus Health Services Act of 2010, VA has hired over 100 Peer Specialists in recent months, and is hiring and training nearly 700 more. Additionally, VA has awarded a contract to the Depression and Bipolar Support Alliance to provide certification training for Peer Specialists. This peer staff is expected to be hired by December 31, 2013, and will work as members of mental health teams.

In addition to hiring more mental health workers, VA is developing electronic tools to help VA clinicians manage the mental health needs of their patients. Clinical Reminders give clinicians timely information about patient health maintenance schedules, and the High-Risk Mental Health National Reminder and Flag system allows VA clinicians to flag patients who are at-risk for suicide. When an at-risk patient does not keep an appointment, Clinical Reminders prompt the clinician to follow-up with the Veteran.

Since its inception in 2007, the Veterans Crisis Line in Canandaigua, New York, has answered over 725,000 calls and responded to more than 80,000 chats and 5,000 texts from Veterans in need. In the most serious calls, approximately 26,000 men

and women have been rescued from a suicide in progress because of our intervention—the equivalent of two Army divisions.

We recently completed a 2012 VA suicide data report, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. We are working hard to understand this issue—and VA and DOD have jointly funded a $100 million suicide research project. We will be better informed about suicides, but while research is ongoing, we are taking immediate action and are not waiting 10 years for final study outcomes. These actions include Veterans Chat on the Veterans Crisis Line, local Suicide Prevention Coordinators' for counseling and services, and availability of VA–DOD Suicide Outreach resources.

The Affordable Care Act

The Affordable Care Act (ACA) expands access to coverage, reins in healthcare costs, and improves the Nation's healthcare delivery system. The Act has important implications for VA. Beginning in 2014, many uninsured Americans, including Veterans, will have access to quality, affordable health insurance choices through Health Insurance Marketplaces, also known as Exchanges, and may be eligible for premium tax credits and cost-sharing reductions to make coverage more affordable. The 2014 budget requests $85 million within the Medical Care request and $3.4 million within the Information Technology request to fulfill multiple responsibilities as a provider of Minimum Essential Coverage under the Affordable Care Act, including: (1) providing outreach and communication on ACA to Veterans related to VA healthcare; (2) reporting to Treasury on individuals who are enrolled in the VA healthcare system; and (3) providing a written statement to each enrolled Veteran about their coverage by January 2015.

Medical Care in Rural Areas

VA remains committed to the delivery of medical care in rural areas of our country. For that reason, in 2012, we obligated $248 million to support the efforts of the Office of Rural Health to improve access and quality of care for enrolled Veterans who live in rural areas. Some 3.4 million Veterans enrolled in the VA healthcare system live in rural or highly rural areas of the country; this represents about 41 percent of all enrolled Veterans. For that reason, VA will continue to emphasize rural health in our budget planning, including addressing the needs of American Indian and Alaska Native (AI/AN) Veterans.

VA is committed to expanding access to the full range of VA programs to eligible AI/AN Veterans. Last year, VA signed a Memorandum of Agreement with the Indian Health Service (IHS), through which VA will reimburse IHS for direct care services provided to eligible American Indian and Alaska Native Veterans. While the national agreement applies only to VA and IHS, it will inform agreements negotiated between the VA and tribal health programs.

This follows the agreement already in place between VA and IHS whereby nearly 250,000 patients served by IHS have utilized a prescription program that allows IHS pharmacies to use VA's Consolidated Mail Outpatient Pharmacy (CMOP) to process and mail prescription refills for IHS patients. By accessing the service, IHS patients can now have their prescriptions mailed to them, in many cases eliminating the need to pick them up at an IHS pharmacy.

Women Veterans Medical Care

Changing demographics are also driving change at VA. Today, we have over 2.2 million women Veterans in our country; they are the fastest growing segment of our Veterans' population. Since 2009, the number of women Veterans enrolled in VA healthcare increased by almost 22 percent, to 591,500. However, by 2022—less than a decade from now—their number is projected to spike to almost 2.5 million, and an estimated 900,000 will be enrolled in VA healthcare.

The 2014 budget requests $422 million, an increase of 134 percent since 2009, for gender-specific medical care for women Veterans. Since 2009, we have invested $25.5 million in improvements to women Veterans' clinics and opened 19 new ones. Today, nearly 50 percent of our facilities have comprehensive women's clinics, and every VA healthcare system has designated women's health primary care providers, and has a women Veteran's program manager on staff.

In 2012, VA awarded 32 grants totaling $2 million to VA facilities for projects that will improve emergency healthcare services for women Veterans, expand women's health education programs for VA staff, and offer telehealth programs to female Veterans in rural areas. These new projects will improve access and quality of critical healthcare services for women. This is the largest number of 1-year grants VA has ever awarded for enhancing women's health services.

MEDICAL RESEARCH

Medical Research is being supported with $586 million in direct appropriations in 2014, with an additional $1.3 billion in funding support from VA's medical care program and through Federal and non-Federal grants. VA Research and Development will support 2,224 projects during 2014.

Projects funded in 2014 will be focused on supporting development of New Models of Care, identifying or developing new treatments for Gulf War Veterans, improving social reintegration following traumatic brain injury, reducing suicide, evaluating the effectiveness of complementary and alternative medicine, developing blood tests to assist in the diagnosis of post-traumatic stress disorder and mild traumatic brain injury, and advancing genomic medicine.

The 2014 budget continues support for the Million Veteran Program (MVP), an unprecedented research program that advances the promises of genomic science. The MVP will establish a database, used only by authorized researchers in a secure manner, to conduct health and wellness studies to determine which genetic variations are associated with particular health issues—potentially helping the health of America's Veterans and the general public. MVP recently enrolled its 100,000th volunteer research participant, and by the end of 2013, the goal is to enroll at least 150,000 participants in the program.

VETERANS BENEFITS ADMINISTRATION (VBA)

The 2014 budget request of $2.455 billion for VBA, an increase of $294 million in discretionary funds from the 2013 enacted level, is vital to the transformation strategy that drives our performance improvements focused most squarely on the backlog.

Virtually all 860,000 claims in the VBA inventory, including the 600,000 claims that have been at VA for over 125 days and are considered backlogged, exist only in paper. Our transition to VBMS and electronic claims processing is a massive and crucial phase in VBA transformation. VA awarded two VCIP contracts in 2012 to provide document conversion services that will populate the electronic claims folder, or eFolder, in VBMS with images and data extracted from paper and other source material. Without VCIP, we cannot populate the eFolder on which the VBMS system relies. The 2014 request for $136 million for our scanning services contracts will ensure that we remain on track to reach this key goal. In addition, the budget request includes $4.9 million for help desk support for Veterans using the Veterans On-Line Application/eBenefits system.

VBA projects a beneficiary caseload of 4.6 million in 2014, with more than $70 billion in compensation and pension benefits obligations. We expect to process 1.2 million compensation claims in 2014, and we are pursuing improvements that will enable us to meet the emerging needs of Veterans and their families.

Veterans Employment

Under the leadership of President Obama, VA, DOD, the Department of Labor, and the entire Federal Government have made Veterans employment one of their highest priorities. In August 2011, the President announced his comprehensive plan to address this issue and to ensure that all of America's Veterans have the support they need and deserve when they leave the military, look for a job, and enter the civilian workforce. He created a new DOD–VA Employment Initiative Task Force that would develop a new training and services delivery model to help strengthen the transition of our Veteran Servicemembers from military to civilian life. VA has worked closely with other partners in the Task Force to identify its responsibilities and ensure delivery of the President's vision. On November 21, 2012, the effective date of the VOW Act, VA began deployment of the enhanced VA benefits briefings under the revised Transition Assistance Program (TAP), called Transition GPS (Goals, Plans, Success). VA will also provide training for the optional Technical Training Track Curriculum and participate in the Capstone event, which will ensure that separating Servicemembers have the opportunity to verify that they have met Career Readiness Standards and are steered to the resources and benefits available to them as Veterans. Accordingly, the 2014 budget requests $104 million to support the implementation of Transition GPS and meet VA's responsibilities under the VOW Act and the President's Veterans Employment Initiative.

Veterans Job Corps

In his State of the Union address in 2012, President Obama called for a new Veterans Job Corps initiative to help our returning Veterans find pathways to civilian employment. The 2014 budget includes $1 billion in mandatory funding to develop a Veterans Job Corps conservation program that will put up to 20,000 Veterans

back to work over the next 5 years protecting and rebuilding America. Jobs will include park maintenance projects, patrolling public lands, rehabilitating natural and recreational areas, and administrative, technical, and law enforcement-related activities. Additionally, Veterans will help make a significant dent in the deferred maintenance of our Federal, State, local, and tribal lands including jobs that will repair and rehabilitate trails, roads, levees, recreation facilities and other assets. The program will serve all Veterans, but will have a particular focus on Post-9/11 Veterans.

Post-9/11 and Other Education Programs

Since 2009, VA has provided over $25 billion in Post-9/11 GI Bill benefits to cover the education and training of more than 893,000 Servicemembers, Veterans, family members, and survivors. We are now working with Student Veterans of America to track graduation and training completion rates.

The Post-9/11 GI Bill continues to be a focus of VBA transformation as it implements the Long-Term Solution (LTS). At the end of February we had approximately 60,000 education claims pending, 70 percent lower than the total claims pending the same time last year. The average days to process Post-9/11 GI Bill supplemental claims has decreased by 17 days, from 23 days in September 2012 to 6 days in February 2013. The average time to process initial Post-9/11 GI Bill original education benefit claims in February was 24 days.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The 2014 budget includes $250 million in operations and maintenance funding for the National Cemetery Administration (NCA). As we move forward into the next fiscal year, NCA projects our workload numbers will continue to increase. For 2014, we anticipate conducting approximately 121,000 interments of Veterans or their family members, maintaining and providing perpetual care for approximately 3.4 million gravesites. NCA will also maintain 9,000 developed acres and process approximately 345,000 headstone and marker applications.

Review of National Cemeteries

For the first time in the 150-year history of National Cemeteries, NCA has completed a self-initiated, comprehensive review of the entire inventory of 3.2 million headstones and markers within the 131 National Cemeteries and 33 Soldiers' Lots it maintains. The information gained was invaluable in validating current operations and ensuring a sustainment plan is in place to enhance our management practices. The review was part of NCA's ongoing effort to ensure the full and accurate accounting of remains interred in VA National Cemeteries. Families of those buried in our national shrines can be assured their loved ones will continue to be cared for into perpetuity.

Veterans Employment

NCA continues to maintain its commitment to hiring Veterans. Currently, Veterans comprise over 74 percent of its workforce. Since 2009, NCA has hired over 400 returning Iraq and Afghanistan Veterans. In addition, 82 percent of contracts in 2012 were awarded to Veteran-owned and service-disabled Veteran-owned small businesses. NCA's committed, Veteran-centric workforce is the main reason it is able to provide a world-class level of customer service. NCA received the highest score—94 out of 100 possible—in the 2010 American Customer Satisfaction Index (ACSI) sponsored by the University of Michigan. This was the fourth time NCA participated and the fourth time it received the top rating in the Nation.

Partnerships

NCA continues to leverage its partnerships to increase service for Veterans and their families. As a complement to the National Cemetery System, NCA administers the Veterans Cemetery Grant Service (VCGS). There are currently 88 operational State and tribal cemeteries in 43 States, Guam, and Saipan, with 6 more under construction. Since 1978, VCGS has awarded grants totaling more than $500 million to establish, expand, or improve Veterans' cemeteries. In 2012, these cemeteries conducted over 31,000 burials for Veterans and family members.

NCA works closely with funeral directors and private cemeteries, two significant stakeholder groups, who assist with the coordination of committal services and interments. Funeral directors may also help families in applying for headstones, markers, and other memorial benefits. NCA partners with private cemeteries by furnishing headstones and markers for Veterans' gravesites in these private cemeteries. In January of this year, NCA announced the availability of a new online funeral directors resource kit that may be used by funeral directors nationwide when

helping Veterans and their families make burial arrangements in VA National Cemeteries.

CAPITAL INFRASTRUCTURE

A total of $1.1 billion is requested in 2014 for VA's major and minor construction programs. The capital asset budget reflects VA's commitment to provide safe, secure, sustainable, and accessible facilities for Veterans. The request also reflects the current fiscal climate and the great challenges VA faces in order to close the gap between our current status and the needs identified in our Strategic Capital Investment Planning (SCIP) process.

Major Construction

The major construction request in 2014 is $342 million for one medical facility project and three National Cemeteries. The request will fund the completion of a mental health building in Seattle, Washington, to replace the existing, seismically deficient building. It will also increase access to Veteran burial services by providing a National Cemetery in Central East Florida; Omaha, Nebraska; and Tallahassee, Florida.

The 2014 budget includes $5 million for NCA for advance planning activities. VA is in the process of establishing two additional National Cemeteries in Western New York and Southern Colorado, according to the burial access policies included in the 2011 budget. These two new cemeteries, along with the three requested in 2014, will increase access to 550,000 Veterans. NCA has obligated approximately $16 million to acquire land in 2012 and 2013 for the planned new National Cemeteries in Central East Florida; Tallahassee, Florida; and Omaha, Nebraska.

Minor Construction

In 2014, the minor construction request is $715 million, an increase of 17.8 percent from the 2013 enacted level. It would provide for constructing, renovating, expanding and improving VA facilities, including planning, assessment of needs, gravesite expansions, site acquisition, and disposition. VA is placing a funding priority on minor construction projects in 2014 for two reasons. First, our aging infrastructure requires a focus on maintenance and repair of existing facilities. Second, the minor construction program can be implemented more quickly than the long-term major construction program to enhance Veterans' services.

In light of the difficult fiscal outlook for our Nation, it's time to carefully consider VA's footprint and our real property portfolio. In 2012, VA spent approximately $23 million to maintain unneeded buildings. Achieving significant reduction in unneeded space is a priority for the Administration and VA. To support this priority, the President has proposed a Civilian Property Realignment Act (CPRA), which would allow agencies like VA to address the competing stakeholder interests, funding issues, and red tape that slows down or prevents the Federal Government from disposing of real estate. If enacted by Congress, this process would give VA more flexibility to dispose of property and improve the management of its inventory.

LEGISLATION

Besides presenting VA's resource requirements to meet our commitment to the Nation's Veterans, the President's budget also requests legislative action that we believe will benefit Veterans. There are many worthwhile proposals for your consideration, but let me highlight a few. For improvements to Veterans healthcare, our budget includes a measure to allow VA to provide Veterans with alternatives to long-stay nursing homes, and enhance VA's ability to provide transportation services to assist Veterans with accessing VA healthcare services. Our legislative proposal also request that Congress make numerous improvements to VA's critical homelessness programs, including allowing an increased focus on homeless Veterans with special needs, including women, those with minor dependents, the chronically mentally ill, and the terminally ill.

We also are putting forward proposals aimed squarely at the disability claims backlog—such as establishing standard claims application forms—that are reasonable and thoughtful changes that go hand-in-hand with the ongoing transformation and modernization of our disability claims system. We are offering reforms to our Specially Adaptive Housing program that will remove rules that in some circumstances can arbitrarily limit the benefit. The budget's legislative proposals also include ideas for expanding and improving services in our National Cemeteries.

Finally, this budget includes provisions that will benefit Veterans and taxpayers by allowing for efficiencies and cost savings in VA's operations—for example, we are forwarding a proposal that would require that private health plans treat VA as a "participating provider"—preventing those plans from limiting payments or exclud-

ing coverage for Veterans' non-service-connected conditions. VA merits having this status, and the additional revenue will fund medical care for Veterans. We are also requesting spending flexibility so that we can more effectively partner with other Federal agencies, including DOD, in pursuit of collaborations that will benefit Veterans and Servicemembers and deliver healthcare more efficiently.

SUMMARY

Veterans stand ready to help rebuild the American middle class and return every dollar invested in them by strengthening our Nation. And we, at VA, will continue to implement the President's vision of a 21st century VA, worthy of those who, by their service and sacrifice, have kept our Nation free. Thanks to the President's leadership and the solid support of Congress, we have made huge strides in our journey to provide all generations of Veterans the best possible care and benefits through improved technology that they earned through their selfless service. We are committed to continue that journey, even as the numbers of Veterans using VA services increase in the coming years, through the responsible use of the resources provided in the 2014 budget and 2015 advance appropriations requests. Again, thank you for the opportunity to appear before you today and for your steadfast support of our Nation's Veterans.

Senator JOHNSON. Thank you.

For the information of my colleagues, we will limit questions to 6-minute rounds to ensure that everyone has a chance to be heard. If needed, we will have a second round.

BLACK HILLS

Secretary Shinseki, I was surprised to find that the fiscal year 2014 budget request includes a request for an authorization for a new residential rehab treatment facility and multispecialty outpatient clinic in Rapid City, South Dakota. This goes against your repeated assurances to me and other members of the South Dakota delegation, and our constituents, that a final decision has not been made regarding the VA's proposed realignment of Black Hills' healthcare systems.

How can we believe that you are honestly still considering other alternatives when the budget sets the VA's proposal in motion?

Secretary SHINSEKI. Chairman Johnson, let me apologize for the language that appears in the budget submission on Black Hills. It wasn't appropriate, and it's an oversight on our part.

As you and I have agreed, this is a dialogue that's underway. I assure you I have not made a decision, and this is also proof that I don't read every line in the budget. It shouldn't have been there, and next time I'll be more thorough.

Senator JOHNSON. Do you intend to notify the authorization committees that this was a mistake?

Secretary SHINSEKI. I will do that.

VETERANS BENEFITS MANAGEMENT SYSTEM (VBMS)

Senator JOHNSON. One of the key elements in the VA's strategy to break the claims backlog is the successful deployment of the VBMS, or paperless claims processing system. I noted from your testimony that the Department plans to have this system deployed by 2013. However, I'm concerned about reports of the system's performance failures.

Will VBMS be deployed on time? Will it work? And when can we expect tangible results from its implementation? In other words, when will this system speed up the process for vets?

Secretary SHINSEKI. Mr. Chairman, let me assure you that VBMS works. As I indicated, we had set in our plan by December 2013 to have it fully fielded. We began fielding in September 2012 and here we are, 6 months later, in 36 of our 56 regional offices. We intend to complete fielding to the remaining 20 as soon as we can. I am confident that it's not going to take us until December.

I believe the reference to the problem that you're hearing about is the last issuance of VBMS. We started with VBMS 1.0, and then 2.0, and 3.0. We just fielded 4.2, which has probably 100 patches associated with it. One of them wasn't functioning properly. Everything else went.

We held this off because it wasn't performing the way we wanted and it was creating some concern. We held it off for a week and retested it. It is finally now updated with 4.2. We're on schedule, and it's functioning.

ACCESS TO VA

Senator JOHNSON. Mr. Secretary, the budget request includes an additional $158 million for medical services in fiscal year 2014, of which $85 million is projected to impact the Affordable Care Act (ACA) on the VA healthcare system. Is this funding intended to implement any aspect of the ACA?

As I said, the ACA is expected to bring more eligible vets into the VHA healthcare system, more specifically, vets who do not currently have health insurance. Will this help VA's goal to give more eligible vets access to VA healthcare?

Secretary SHINSEKI. Mr. Chairman, I'm going to call on Dr. Petzel here in a second to provide some details, but I'd like to be very clear up front.

VA will continue to provide eligible veterans with high-quality care, comprehensive healthcare, and benefits they have earned. That will not change.

We do modeling whenever we think there's going to be a major change in the delivery of a service. Through our modeling, it was suggested that we might have a modest increase. The $85 million is put in there to be prepared in case this is realized.

I will assure you that the veterans who are currently using VA will see no degradation in the quality or the timeliness of the service they receive.

Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Mr. Chairman, as the Secretary relayed, the Affordable Care Act will not affect the care that we deliver to veterans. As he said, there is a modest increase that may occur as a result of the implementation of it.

There are two aspects to the Affordable Care Act, just very briefly: First is the mandate that one have insurance; the VA healthcare system does provide the minimum essential coverage, as does our CHAMPVA program. Second is the effects that it may have on Medicare.

When we looked at those two aspects of the Affordable Care Act and evaluated the potential impact on VA, as the Secretary has mentioned, the indications were that there may be some net in-

crease in the number of people moving to the VA. Thus, the $85 million is to cover the cost of that increased care.

Senator JOHNSON. Senator Kirk.

Senator KIRK. Let me do a drill down here since the ACA might be somewhat controversial.

You guys are basically saying, for an Illinois veteran who has signed up to the Illinois exchange, it's more likely they seek care in the VA, is what you're estimating?

Secretary SHINSEKI. I wouldn't say we have specifically focused on Illinois. I think it has to do with whether States make decisions regarding Medicaid, or not.

Senator KIRK. I am going to interrupt you one second. Usually, my questions kind of tend to the State of Illinois.

Secretary SHINSEKI. Yes, I know. I'm not familiar with where Illinois stands on its decision.

It was based on those decisions by States that, we thought there might be an influx, a slight influx of veterans.

CLAIMS BACKLOG

Senator KIRK. I will massively suck up to my chairwoman and ask about Baltimore, where, I understand, Madam Chair, I understand that we're up to 380 days for adjudication of VA disability in Baltimore. I think you're extremely concerned about Baltimore veterans.

Senator MIKULSKI. I'm hot about it. But, please, go ahead.

Senator JOHNSON. Go ahead.

Senator KIRK. Thank you, Mr. Chairman.

I just want to say one thing. I understand that in Chicago, it is at 431 days, and we would want to shorten it, as you have laid out.

Secretary SHINSEKI. Senator Kirk, I'll just say that this is something we've been working on for a number of years now.

We were, 4 years ago, a paper process. And it's a huge paper juggernaut. We get paper from DOD. We process paper. We get claims submitted in paper. That's traditionally the way things are done.

After over a decade of war now, requirements have gone up. There's greater complexity. If we're going to end the backlog, we have to do something different than just to continue to process the way we have been.

What we have done is approach DOD and ask for electrons. They have agreed that, by the end of this year, they're going to begin sending us their records in electrons. Also veterans need an online capability to submit claims electronically. We are now providing that.

We have about 800,000-plus claims today already in our inventory. We're taking the ones that it's smart to do and putting them through a scanning process, creating electrons to be stored into our electronic tool as we stand the system up.

There are some that are already started in paper. It makes sense to just finish them in paper. So we're just going to suck it up and keep driving on.

But at the same time, now we need a catcher's mitt to gather all these electrons, and that's what VBMS is about. It's taken us about 2 years to develop. Six months ago, we started fielding it. As I said before, here we are 6 months later, we're at 36 out of 56.

This comes together this year. It's what we've been planning. The increase in the number of claims in the inventory is a set of decisions we made in 2010 that was intended to clean up some unfinished business.

This was Vietnam veterans, and agent orange with three diseases were added to the workload. These were new adds, not anything that VA had been resourced to deal with. Desert Storm 1 had nine diseases associated with gulf war illness that were added to the workload; more paper workload.

Finally, for combat veterans, post-traumatic stress disorder (PTSD) is as old as combat. What we have done is to just say, if you have verifiable PTSD and you've been in combat, then whatever other reasons there may be, this is good enough. Let's go ahead and take care of our responsibilities here.

Those three decisions have added to the inventory.

Three years ago, when we made the decision, in testimony we said, "Look, this is going to grow the inventory, but we're going to build an automation tool that in time will take this down." I think we even predicted that the number of waiting days was going to go up fairly high.

It has. All of that's borne out. It doesn't excuse the fact that veterans are waiting too long for decisions. I am committed to ending the backlog and correcting all of this.

That's why this year's budget, it increases VBA, our benefits administration, by 13.6 percent, and increases the information technology tool, VBMS, among others. Increasing the information technology (IT) budget by 10.8 percent is critical for us to make this crossover from what has been a paper process to a digitized one.

Senator JOHNSON. The chairwoman of the full committee has joined us. At this point, I want to welcome her, and call upon her for any statement or questions she may have.

Chairwoman Mikulski.

Senator MIKULSKI. Thank you very much, Senator Johnson. And thank you for the great job you've been doing.

And, Senator Kirk, it's so good to see you back at the table.

I used to chair the VA in the old VA–HUD days, so it's déjà vu to rejoin you at the table.

And I wanted to come and just, first of all, affirm my support for both of you. And I note that the President has submitted a Department of Veterans Affairs appropriations request of $152.7 billion.

This is the number three subcommittee under the entire full committee. Number one is Defense at $600 billion. Then there's HHS-Labor, which is really three agencies. And then the Department of Veterans Affairs itself at $152.7 billion.

$86 billion of that is in mandatory. $63 billion of that is in discretionary. And then there's $3 billion in third-party collections.

So there's a tremendous amount of money and resources that we need to ponder in what is the most effective way to work with the executive branch to serve our veterans.

I want you to know, we intend to follow regular order. We hope to mark up at a topline of the $1.05 trillion, which is mandated by the Budget Control Act. The House Budget Act number is $966 billion, so there are some resolutions that need to occur.

But we're going to work together on this and work with you on how you want to do this.

BALTIMORE REGIONAL OFFICE

So I wanted to come to affirm our support for working together. But like you, I'm ballistic about this backlog, and I was mortified over the fact that Baltimore was one of the top worst claims areas in the entire Nation.

Senator Kirk, you already gave some of the numbers. But we were in the top three of a very embarrassing list.

Now, General Shinseki, you came to Baltimore, and I appreciated that, with your team. And then you made certain promises, which are being followed through.

But what happened is, that as you said now, the entire Baltimore office is being shut down for training. Are you aware of that?

Secretary SHINSEKI. I'm not aware they've been shut down. My understanding is they're continuing to process claims. Training has been integrated into their day-to-day work.

Senator MIKULSKI. Well, sir, that's not the way it is on boots on the ground.

The entire Baltimore office is now in training. There is one person answering the phone—one person answering the phone.

Now, there were 10 people on the phone to answer our questions, 10 people from there. We can't have this, that we're going to shut down a whole office so they're more fit for duty, which we like the training, which you said you would do, and we're excited about that. But we can't shut it down. Or if we can, we need you to send temporary claims processors to Baltimore to take in the cases and begin the methodology that's established while this 4-week training is going on.

Secretary SHINSEKI. I understand we have help teams that have been added to Baltimore. Let me ask Secretary Hickey for some details.

Ms. HICKEY. Chairwoman Mikulski, my apologies to you. There was some miscommunication, I believe, to you about the nature of what was happening in Baltimore. So I will accept responsibility for that miscommunication.

There are 4 hours a day where they are literally still working claims. The other 4 hours, they are in a class, but while they're in that class, but they're working live claims that belong to the Baltimore regional office.

That's the way the training is designed. It's designed so they actually work claims, and they go through a training process while that happens.

In the meantime, I know about your concern, and I'm very sensitive to that concern. We are continuing to get the support of three other regional offices, as I committed to you, to ensure that the Baltimore backlog is coming down. They continue to do those claims and are still working them.

We are also looking to see if we can bring one more team in while they're working in the training environment to supplement the additional support during the training period.

I will share with you that we have already seen production increases in Baltimore since we visited with you. I appreciate your taking time out of your schedule to visit Baltimore.

Not only increases in production have been seen, but also increases in the quality, as a result of bringing in some of those help teams, with subject-matter experts who come in and help coach, and facilitate some improvements in Baltimore.

Senator MIKULSKI. Well, I think we need to talk about it. I don't want to take the time of the subcommittee.

There has been a breakdown in communication. And there's a breakdown in communication even in the way the director of that office talks with us. He was silent on the phone.

When we asked, "Where would these records go?" we heard they were in the cloud. Nobody could tell us where these records were going. We're not happy.

But rather than go on and turn this into a discussion on Baltimore, what I fear is that this is the problem everywhere, and not only a backlog, but then the lack of communication. Yes, they do work in the afternoon, but we hear it's a very few set of coaches with a very few set of cases with coaches.

So let's really talk and get this straight, and let's not take the time.

COLLABORATIONS

I'd like to go nationally, and if I could, General Shinseki, did I hear you right—and it goes to what we're all raising—we understand that in order for VA to do their job, they need the cooperation of four other agencies, plus the National Guard. They need the cooperation of VA, the Social Security Administration (SSA) to send you records, and, to a certain extent, the Internal Revenue Service (IRS). Is that correct?

Now, in the hearing, does VA really cooperate with you? Or you don't want to say, because you're a good guy, and used to be in the chain of command, and hoorah, hoorah?

Secretary SHINSEKI. No. Madam Chairman, I would tell you that I spent 38 years in uniform, as you know. In all that time, I knew there was a VA, but there was almost no interaction between my duties in uniform and the Department.

And so when I became Secretary of this Department, I realized how little education I had received. One of the first things that Secretary Bob Gates and I did was to agree, with a handshake as we were standing in line waiting to be sworn in to our respective duties, to bring our departments together.

And so it began with Bob Gates. It continued with Leon Panetta. It continues now with Secretary Hagel.

The whole point is that our departments culturally look in two different directions. That's not good enough. We are working to bring our departments into greater synergy.

Part of that has to do with this seamless transition that we talk about, which includes getting electronic records from DOD, and allowing us to match up.

Senator MIKULSKI. Well, is that happening?

Secretary SHINSEKI. In terms of information that arrives for us to be able to use, with personnel records, we have an agreement

with DOD that by December of this year, 2013, we will begin to receive electronic records.

We're working on—and this is probably the more critical one—a single, common, joint, integrated electronic health record that is open in architecture and nonproprietary in design. All those terms are code word to force us to come up with a single system that applies to both departments.

ROUNDTABLE

Senator MIKULSKI. Thank you.

Mr. Chairman, Senator Kirk, colleagues, I'm going to suggest this, as the full committee chair, the subcommittee does their business, and they've been doing a great job on this. But as the full committee chair, I thought I would convene a roundtable of the four agencies that have to serve our veterans, and actually get Hagel in the room with Shinseki, and their assistant deputy coordinator of the health records, and techno-micro-chips. Does this sound like a good idea?

Senator KIRK. That sounds like an awesome idea. We get both secretaries in here to explain why we haven't combined the two systems.

And I would give you a little partisan edge on that, a partisan edge. By that I mean, in VA versus DOD, and just say that I don't understand why the taxpayer has to pay for two totally separate systems.

And I want DOD to insist on why they need to have a separate system, that I think we should go date-certain with just VistA, which is the VA system, and force DOD to say why we have to slow down and have a separate system.

Senator MIKULSKI. Well, this subcommittee has been the driving force. I thought we could get DOD, bring Social Security and IRS in. And I'd really love for Appropriations to be the committee that cracks the code on the VA backlog. It would be a great tribute to you as a veteran.

Senator JOHNSON. Madam Chairwoman, that is an excellent idea. The details need to be figured out, but I'll take charge of that.

Senator MIKULSKI. Yes. And we look forward to working with you to do that. Thank you.

Senator JOHNSON. Senator Reed.

Senator REED. By order of appearance, or if it's back and forth, I'd be happy to yield to one of my colleagues.

Senator JOHNSON. Senator Kirk had the last comments. I'll turn to Senator Reed.

Senator REED. Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

TRANSITION ASSISTANCE

I have a series of simple questions, which might actually be pretty dumb questions. But is entry into the VA automatic upon discharge from the service? Or does a discharged military person have to formally apply to VA?

Secretary SHINSEKI. Today, it is not automatic. But this is what the Secretary of Defense and Secretary of VA are working on.

As you know, the Department of Defense has a transition assistance program. That is their transition program.

We have included ourselves in that process before the uniform comes off. Whatever claims that need to be addressed, we want to start that early.

Senator REED. It just seems to me, Mr. Secretary, and, you know, you said you spent 38 years in Active Duty. The day you raise your hand as an E–1, or whatever, you're probably going to be a veteran with perhaps 1 percent, 2 percent deviation there.

Have we missed the focus? Shouldn't we be looking not at the transition point from active service to another service, but actually the point of induction, or basic training?

Secretary SHINSEKI. We agree. That's what we've been working on. Today, we at VA, have created an eBenefits automation tool. As young men and women are being inducted into the military, they have access to that tool.

As you know, they participate in some of our education programs, and mortgage programs. For the military, with servicemembers group life insurance, we are their insurer.

So this ought not to be a decision to be made when the uniform comes off. It ought to be seamless. It ought to be mandated. Making that commitment is all about what the electronic health record is designed to do.

Senator REED. Does that require any further legislation, or that's within your authority today to enroll? Pick an obvious point, completion of basic training, you're enrolled in the VA system. You get information, you're eligible for some programs, but not all programs. Can you do that?

Secretary SHINSEKI. I would say there's a certain definition, a time of service, before a requirement for veterans status is rendered. Then, as you know, depending on the character of discharge, that status could change.

Senator REED. Right, but that's——

Secretary SHINSEKI. I'm not expert enough on it for an answer today. Let me give you an answer for the record. I think what we're getting at here is, let's make this truly seamless between the departments, and I think we can work on that.

[The information follows:]

VA strives to reach out to all separating servicemembers to ensure they are aware of and can access VA benefits, healthcare and other services. As an example, VA sends a personalized letter to all recently discharged veterans reminding them of these benefits.

In August 2011, the President called on the Department of Defense (DOD) and Veterans Affairs (VA) to lead a task force with the White House economic and domestic policy teams and other agencies, including the Department of Labor (DOL), to develop proposals to maximize the career readiness of all servicemembers. This DODVA Veterans Employment Initiative Task Force is one element of the plan to reduce veteran unemployment and to ensure that all of America's veterans have the support they need and deserve when they leave the military, look for a job, and enter the civilian workforce.

To meet the President's call for a "career-ready military," the DOD–VA Veterans Employment Initiative Task Force developed a new training and services delivery model to help strengthen the transition of our servicemembers from military to civilian life as they become veterans. This revamped TAP curriculum, named Transition Goals, Planning, Success (Transition GPS), is meant to provide servicemembers with a set of value-added, individually tailored training programs and services to equip them with the set of tools they need to pursue post-military goals successfully. This model represents an improved DOD/VA/DOL Transition Assistance Program (TAP).

The new model was implemented in November, 2012 and is consistent with Public Law 112–56, the VOW to Hire Heroes Act of 2012 (VOW Act) which requires mandatory TAP participation of members of the Armed Forces. This has significantly increased VA healthcare benefits awareness and application opportunities for all separating servicemembers. Long before these changes, VA has had a long standing effort in place to assist veterans with enrollment into VA healthcare system through participation in various DOD demobilization events. An application for healthcare benefits, named the 10–10EZ, must be completed by all veterans to enroll in VA healthcare. As part of the outreach activities, VA works directly with transitioning servicemembers to complete this form. It can also be completed via the Internet and over the phone.

In addition, we now enroll every new servicemember in eBenefits as part of the mandatory TAP enrollment. eBenefits is the highly successful VA and DOD online Web site/portal providing a central location for veterans, servicemembers, and their families to research, find, access, and manage a growing list of benefits and personal information such as certificates of eligibility for VA home loans, Post-9/11 GI Bill enrollment information, and service verification (DD 214).

The below Federal Register notice regarding "Duty Periods for Establishing Eligibility for Health Care" below shows the complexity of the question/response.

https://www.federalregister.gov/articles/2013/05/09/2013-11051/duty-periods-for-establishing-eligibility-for-health-care?utm__campaign=subscription+mailing+list&utm__medium=email&utm__source=federalregister.gov

The Virtual Lifetime Electronic Record (VLER) project being worked on by VA and DOD will allow VA, DOD, and others to easily share information on servicemembers and veterans and enable VA to provide proactive care and benefits to veterans that they have earned and deserve. The end goal of VLER is to share health, benefits, and administrative information, including personnel records and military history records, among DOD, VA, HHS, SSA, private healthcare providers, and other Federal, State, and local governmental partners; and enable caregivers, clinicians, and benefits providers to view all relevant information about a veteran securely, regardless of where it was documented, in a secure, electronic record.

Senator REED. Well, again, I think the sooner you do it, not the discharge point but the point where that young man or woman is going to be presumably on Active Duty for 3 years, then become a veteran, gives you more time and actually acclimates them to the system.

INTEGRATED DISABILITY EVALUATION SYSTEM (IDES)

Let me shift gears, basically. The Integrated Disability Evaluation System (IDES), which you're working on, ideally—unfortunately, we had two systems.

We had a DOD evaluation of your disability, and then we had a separate VA system, and that was regulatory arbitrage, et cetera. And it didn't help the veterans. Now you're trying to make an integrated system. That's the goal.

I'll just ask another sort of dumb question. If you have that integrated disability system, if you have actually assessed that individual, before they leave the service, why would they technically have to make a claim? Couldn't you automatically make the benefits available to them based upon their evaluation?

Secretary SHINSEKI. I would agree that I think that sort of approach makes sense, but I think we have a requirement to make sure we do a complete investigation and consult with the individual on their disability.

There may be things that are not in the record. I'm thinking of the kinds of things some youngsters may prefer not to be in the record. Just looking at the record alone may not be complete enough.

We want to give veterans an opportunity to lay out the things that they may have masked for——

Senator REED. Well, you have as much sensitivity to how soldiers, sailors, marines, and airmen think and act than anyone in this room.

But it seems to me that if the goal is to have one evaluation complete of their health, psychological, physical, et cetera, it might not be fully complete because of lack of disclosure, but at least that's a starting point for automatic benefits.

CLAIMS EXAM

Now, subsequently, and it could be 5 years later, if someone discovers that they have a condition they weren't aware of, well, that is the time for a claim. But I would think that would speed up the process and be more rational.

What I observed and what you observed, too, is it was sort of people were trying to get the highest possible DOD disability evaluation before they left so that they were—you know, they wanted to leave but they didn't want to leave. They were in that situation. Then they had to go through a whole separate process at the VA.

It just doesn't seem to be efficient nor helpful for veterans.

Secretary SHINSEKI. Well, Senator, we have moved to the single exam, a separation exam, and tried to reduce as much overlap on these things.

There was a little difference when we conducted two separate exams. The youngster who wants to remain in uniform wants the lowest percentage adjudication. The youngster who's getting out wants the better one. And so I can understand why there may be a different approach in DOD.

Once the decision is made that the youngster is not going to be able to be retained for whatever medical reason, then the single exam, which is the way we've gone, by VA, will govern both decisions, both their departure and then their arrival to us.

Senator REED. Again, thank you, Mr. Secretary. My time has expired. Thank you for your service. Thank you, ladies and gentlemen.

Senator JOHNSON. Senator Hoeven.

Senator HOEVEN. Thank you, Mr. Chairman.

And, Secretary Shinseki, thanks for being here. Thanks for the meeting in your office recently with Senator Collins and Senator Murkowski. I thought it was very helpful and appreciate you taking time to do that, as well as your commitment to our veterans, your service and your commitment to our veterans.

Also, I appreciate very much that you've come out to the VA Health Center in Fargo, which serves a lot of North Dakota and Minnesota as well, and I think does a phenomenal job.

LEASE

One of the things that's been really important for us is getting another outpatient clinic in Devil's Lake, North Dakota, and I've talked to you about this before.

And I believe, as a follow-up, your staff indicated to me that they're planning to have a lease in place for that facility in August of this year, and then have it open by December.

I want your commitment that we're going to get it open this year. We've been working to get that for some time and maybe just comment on the length of time it takes, because last year we talked about getting it, which, again, we appreciate very much and that they're very much looking forward to in Devil's Lake, but just your comments on the length of time or what's required to set it up and, hopefully, a commitment that we'll have it in place this year.

Secretary SHINSEKI. Let me call on Dr. Petzel for the opening.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Hoeven, we've been talking about the clinic at Devil's Lake since I was a Network Director in Minneapolis, which goes back a couple of years. There have been difficulties in coming to an agreement about the kind of clinic, et cetera.

That's on track now, and we expect to make an award for space in August 2013. The planned occupancy is December 2013.

I will keep track of that, and we will provide feedback to your staff periodically about how we're doing with that timeline.

Senator HOEVEN. Thank you, I appreciate it. We're very much looking forward to that facility. It'll make a real difference for our veterans. And so, if you will stay in touch with us on it, I'd appreciate it very much.

SUICIDE PREVENTION

The other thing, Mr. Secretary, I'd like to just touch on again, two of the things that we've been working on I know you're very dedicated to as well, on behalf of our veterans, are both suicide prevention and also dealing with PTSD.

Would you talk about how in this budget we're doing more to make sure that we're addressing these very serious challenges on behalf of veterans, both the suicide prevention and addressing their needs in regard to PTSD?

Secretary SHINSEKI. Senator, let me start and then let me ask the good doctor, Dr. Petzel, to comment on our approach to suicides.

I would just say up front, one suicide is a tragedy and it's one suicide too many.

We go at this with a lot of energy and, as you know, we have put in place a national crisis line for veterans in Canandaigua, New York. In the last 5 or so years, there have been over 740,000 phone calls.

I think important in that number is that more than 26,000 of them were suicides in progress. They were intervened and people were taken care of.

We've watched the numbers of calls continue to go up but the number of crisis calls have begun to taper off a bit. What we interpret here is that calls are coming in earlier as opposed to in crisis. People are being referred to treatment. The treatment they're receiving works.

We're watching our suicide numbers, which are still high at 22, that is a rate of 22 a day, staying flat and not necessarily spiking, as we have seen elsewhere.

We believe we have a good set of treatments and the opportunity to medicate folks properly.

Let me call on Dr. Petzel.

Dr. PETZEL. Thank you, Mr. Secretary.

Again, Senator Hoeven, suicide is a national tragedy, and suicide amongst veterans, I think, is even a deeper tragedy. This, PTSD, and depression are the results of their service experience and are sort of the unseen wounds of war.

I think we have a tremendous obligation in the VA to find ways to deal effectively with these things.

Just briefly, our mental health budget is $7 billion. We're going to be spending almost $500 million more this year in 2014 rather than we have spent this last year.

In terms of PTSD, there are about 500,000 veterans with that diagnosis, 119,000 of them come out of this present conflict. We'll be devoting, again, about $500 million to those veterans and their treatment.

We, in addition to that, have a research budget of almost $49 million in PTSD research within VA itself, and then a cooperative effort with DOD that takes $50 million from the VA and $50 million from DOD over a period of 5 years and combines into two research projects on PTSD and traumatic brain injury (TBI).

OUTREACH

Just a few words about suicide, the VA has a highly integrated approach to suicide, and we're fortunate that we have this national system that allows us to do this level of integration that you can't necessarily do in other venues. For veterans, we have the crisis hotline and, as the Secretary mentioned, it has been very effective. Almost 800,000 calls and 26,000 rescues; people prevented from harming themselves who were in danger of harming themselves.

We have suicide prevention coordinators at every single one of our medical centers and a team of both outreach and case management mental health professionals for people that are deemed to be at high risk for suicide.

Then we have a public service campaign that we're involved in, in combination with the Department of Defense, to, pardon the expression, destigmatize suicide and destigmatize mental health. It's called, "Make the Connection," and it's vignettes by people who have suffered from mental illness or have attempted suicide, urging people to make that connection with the VA, telling them that this is not something that they should view with trepidation, et cetera.

It's been a very effective campaign, and I think it has been responsible for the fact that we've seen about an 88,000 veteran increase in the number of people we're treating for mental health.

Senator HOEVEN. Doctor, thank you.

And, Secretary, this absolutely has to be an area of emphasis, along with your emphasis on homelessness. I encourage you to involve the veterans groups. I think they're tremendous, can be a big help for you in this area. And, of course, share my concern on the disabilities claims, and I know you're working on that very diligently and know how important it is.

But this area of suicide prevention, PTSD, as well as homelessness, has to be an area of emphasis. And hopefully, you'll reach out to the veterans groups and get them to help, too. I think it's a tremendous network.

Secretary SHINSEKI. We will do that outreach, Senator. Just to underscore how important we think it is, I think Dr. Petzel said very quickly that, in mental health this year, our budget is over $7 billion for mental health alone. If we were to look back from 2009 to the 2014 timeframe, our investments in mental health have gone up nearly 57 percent.

So this is an area of importance to us, and we will continue to emphasize that care.

Senator HOEVEN. Thank you.

Senator JOHNSON. Senator Udall.

Senator UDALL. Thank you, Chairman Johnson.

And thank you, Secretary Shinseki, for being here today and bringing your very able team to appear before us.

And let me say, from my perspective, I very much appreciate your many years of service both in and out of uniform. And I also appreciate the time you took to spend with me talking through New Mexico veterans issues and veterans around the country.

New Mexico is a very rural State. And as you're aware from our discussions, in rural New Mexico, as well as rural areas throughout the country, it can be very difficult to recruit doctors and nurses and staff to serve in rural clinics, including VA clinics.

RURAL VA CLINICS

What is the VA currently doing, and how will this budget support the recruiting and retention of qualified personnel to serve at rural VA clinics?

Secretary SHINSEKI. Let me call on Dr. Petzel about the recruiting and retention efforts.

Dr. PETZEL. Thank you, Mr. Secretary.

Senator Udall, you put your finger on an issue that is important to us, and that is being able to provide medical care in rural America. Forty percent of our veteran population lives in rural or highly rural areas. There's a cascade of things that we do. Let me just quickly go through them.

Number one, we have community-based outpatient clinics, 121 of those clinics around the country. We have the vet centers, which are scattered into some very rural areas, and the mobile vet centers, 70 of them that can go out to other areas.

The largest growing way that we do this is telehealth. And I am getting at the recruitment. We are the largest purveyor of telehealth in the country, and we are now setting up separate individual telehealth clinics where we have a clinical professional, perhaps not a physician, at a site where patients can come in and be connected to their provider via telehealth. It would be a primary care or specialty care.

It began in Colorado, and now it has spread across the country. It's one of the things that we're going to be using in New Mexico to help us supplement the care that we're delivering in rural America.

In terms of recruitment——

Senator UDALL. Dr. Petzel, let me stop you there. So, even for primary care, you're using telehealth?

Dr. PETZEL. We can. Yes, sir.

Senator UDALL. And when you do that, have you taken a reading of satisfaction of vets with doing telehealth for primary care? I mean, I'm wondering from a perspective of seeing that most people like to meet with their doctor in person. And I can understand, and I think everybody can, the telehealth for specialists and things like that.

But as you do that, I think it's very important that you try to take the temperature of veterans in terms of how they feel about not ever seeing an actual doctor in person.

And that's the thrust of this question of mine, because when you see the clinics, at least in New Mexico and I bet this is across the country, what happens is you'll have big gaps. They'll lose a doc, and then it will be 18 months or 2 years before you're able to get another doctor.

And so if you can fill it with telehealth, that's fine, and have a good satisfaction level, but the thrust of my question is really going to the recruitment of docs into these areas.

And maybe the mobile option you're talking about is a good one, too. The reality is many of these doctors and other professionals don't want to live in these rural areas, and so it's very hard to get them there.

And you may want to try to team up with the medical schools. I mean, we have a big problem in New Mexico because our medical school on the day of graduation—we invest in all this; the State of New Mexico puts in money—75 percent of our graduates leave the State on that day of graduation. And so we're trying to work with them to see how do we keep the people there, and then how do we also get them in rural areas.

Please, go ahead.

Dr. PETZEL. Senator, just a quick word about the telehealth clinics. The patients love it. They like it because, number one, there is a clinician there. There's a clinical person, usually an R.N., but they don't have to drive 80 miles or 100 miles to see their doctor. They can see this person face-to-face.

Many of the things that you would do in a visit face-to-face are done. Blood pressure is transmitted electronically, an EKG, et cetera. So the satisfaction levels are higher than we see in our clinics.

Now just briefly about recruitment, salary is an important thing. We have tremendous flexibility in terms of salary. Providing the support around that physician is important, and we can do that.

We don't have any more difficulty, generally, recruiting into highly rural areas than the communities do. It's just a very difficult task to get people who haven't lived in a small town to come to a small town, and their wives have some influence on doing that, too.

We are looking at scholarships to individuals where we select people that come from rural communities, provide them with support while they go through medical school, and they have an obligation then to us for a period of 3 or 4 years, depending on how long we've been providing them a scholarship, to go back to a rural community. I think that's going to be very effective.

Your medical school in New Mexico, I think, is doing some of those similar things.

Senator UDALL. Yes, they are. They are.

TRANSPORTATION

Just quickly, my second question was about the travel that veterans—you know, many times in New Mexico they have to travel 5 and 6 hours to get to the VA center in Albuquerque, sometimes spend the night, and then come back. And it takes a person from the family or others to take time to drive them when they're older.

I assume telehealth is some of the answer there, but part of my question is to ask about what this budget does to increase transportation options for vets, in terms of trying to travel up to get specialized care in these centers.

Dr. PETZEL. Thank you. That is an excellent question.

The budget has in it money for the Veterans Transportation Network, which is a network that the VA is setting up to provide transportation services in these rural areas.

In addition to that, there's a second element, and that is grants to other organizations, usually service organizations, to provide transportation for veterans.

So there's a substantial—I would have to get back to you with the exact amount—there's a substantial amount of money in there to provide transportation services in these rural areas.

[The information follows:]

The budget provides money for the Veterans Transportation System (VTS), a network that VA is setting up to provide beneficiaries not otherwise eligible for VA travel benefits and with access issues, including those in rural areas, a way to transport to VA healthcare. Transporting veterans to specialized care is enabled through the use of American Disability Act vehicles supplied by VTS. Such vehicles have the capability to transport veterans requiring wheelchair, scooter or needing boarding assistance: all vehicles are equipped with passenger lift ramps. VA currently funds VTS staff and vehicles at 44 facilities with an additional 20 facilities scheduled to begin implementation this fiscal year. VA hopes to have VTS systemwide by 2015. VA has included this initiative in the fiscal year 2014 President's budget request. In 2012, Congress authorized this program for 1 year. In the fiscal year 2014 budget, VA has requested that Congress extend this authorization. Without the proposed extension, it is possible that VTS will need to be significantly reduced or curtailed in January 2014, particularly in rural areas of the country. S. 455 and H.R. 1702 in the House have been proposed to resolve this issue.

In addition, the Grants for Transportation of Veterans in Highly Rural Areas program, created in response to a congressional mandate in section 307 of Public Law 111–163, will provide grants to eligible entities to assist veterans in highly rural areas through innovative transportation services to travel to VA medical centers, and to otherwise assist in providing transportation services in connection with the provision of VA medical care to these veterans. VA recently published required program regulations and will be soliciting grant applications shortly. More information can be found here: https://www.Federalregister.gov/articles/2013/04/02/2013-07636/grants-for-transportation-of-veterans-in-highly-rural-areas. VA has included this initiative in the fiscal year 2014 President's budget request.

Senator UDALL. Good. I hope you'll do that. Thank you very much.

And sorry for running over, Mr. Chairman.

Senator JOHNSON. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

This is a very important discussion to be having, particularly as to how we care for our veterans in these highly rural areas.

And you mentioned the transportation fund. In far too many of Alaska's communities, we're simply not connected by road; 80 per-

cent of the communities in the State of Alaska are not accessible by road, so we've got to fly. So the expense is considerable.

And then, of course, when you're in town, you have taxi, you have to rent a car, you have overnight accommodations.

And so how we provide for those who are—we call them off the road system in Alaska—is a huge issue for us.

One of the things that I thank you for your leadership, Secretary Shinseki, in Alaska, we have an agreement between the VA and the native health system, where the veterans can go to the Indian Health Service (IHS) facilities for that level of care. So it's within their region.

It might not necessarily be in their village, but it's within their region so they don't have to fly to the major cities for this level of care.

And it was something that Senator Stevens and I had worked on. We think that it can be an opportunity, particularly in very rural areas, whether it's South Dakota or New Mexico. It was a great idea, and we want it to work. And the VA has really led on this as they have led with telehealth.

HEALTHCARE

One of the things that I'm hearing anecdotally is from one of the larger and better health systems in the State. They're saying that they're not seeing the patient loads that they had expected. We're trying to drill down into this and find out, is it lack of publicity that the program is available? Is it lack of unfunded travel that's prohibiting them from accessing it?

We're trying to understand how we can make it better, because we recognize we're never going to be able to get the providers out into these remote areas. So if we can work within existing systems, we've got more of an opportunity.

So, Secretary, if you can address that. I know Dr. Petzel has been working on this, of course, for years diligently with us. But we want to try to make this work. We think it has great promise.

Secretary SHINSEKI. That's certainly our intent. I was not aware that we haven't seen the response in the local clinics, and we'll certainly get on that.

For this discussion about delivering healthcare across the country, our commitment is a veteran living in a rural area or a remote area has the same entitlement to access and to care. That's what we're committed to.

There isn't a cookie-cutter approach to this. It affects everything from recruitment and retention bonuses to having an affiliation with a local medical school and bringing together VA's resources with what's already there. We have a memorandum of understanding (MOU) with the Indian Health Service to provide services that veterans can get access to, and we reimburse for those services. We're not trying to deliver something that's already available. Telehealth and telemedicine give access wherever the veteran is able to enter the VA system.

So it's sort of "all the above." There is no cookie cutter that says, since this worked in New Mexico, it'll work in Alaska. We tune these tools up as the situation needs.

And certainly, as Dr. Petzel says, a challenge is recruiting folks to go to some of the rural areas. The scholarship program here in small numbers is intended to get a youngster, a promising youngster, out of those communities, help with their education, and then go home and working for the VA. That's a work in progress and the next initiative we're trying to seed.

Senator MURKOWSKI. Well, if we can work with you to identify how we might be more effective in reaching our veterans in these highly rural areas, we would like to do that with you.

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

I'd like to ask about what is going on within the VA system as it relates to amyotrophic lateral sclerosis (ALS)?

And, Mr. Secretary, you and I have had this conversation before about Lou Gehrig's disease, the fact that VA has granted ALS the presumption of service connection, as we know that those who serve in the military are twice as likely to develop ALS as those who have not served.

We recognize that there are certain technologies that are out there that allow for the individual who is afflicted with this disease to just live an easier quality of life as they deal with this very degenerative and very debilitating process.

But there are certain procedures that the VA has not accepted. One, for instance, is this diaphragm pacing system. I mentioned it at the breakfast that we had visited at, Mr. Secretary.

And this is a process that allows the diaphragm to keep moving when it begins to fail from ALS. The pacer was granted humanitarian status under the Food and Drug Administration (FDA). Insurance covers it as it does for Medicare.

But apparently, these life-extending measures are not recognized within the VA system. And we've had to work within the VA to try to push to provide a level of assistance.

It would seem to me that given that the VA has granted ALS the presumption of service-connection disability, there ought to be some consistency in the standards, so that these individuals that are faced with this horrid disease don't have to fight the VA to get some assistance with some life-extending therapies.

So I don't know if you have an answer for me today, but I feel like I must raise it on behalf of the people who are afflicted with this. Their life should not be made that much more difficult towards the end, when they have to take on the system.

Secretary SHINSEKI. Senator, I agree. We discussed the diaphragm pacing system during our visit together. Let me give you a better answer for the record. We're still investigating this.

But I agree with you, that if we've recognized ALS as a service-connected condition, we ought to provide all the care and benefits that go along with caring for our veterans.

[The information follows:]

VA has used the diaphragm pacing system (DPS) for veterans with amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease since 2008. DPS is considered when the Veteran with ALS has threatened respiratory insufficiency that is not better managed by other means that are not agreeable to the Veteran. Other means include a pressure supported bilevel positive airway pressure, or BiPAP. The BiPAP supports both inhalation and also exhalation by lowering the positive airway pressure to facilitate exhalation.

Senator MURKOWSKI. Well, I appreciate that, and I know that those that are afflicted and their families care a great deal as well.

Secretary SHINSEKI. Thank you.

Senator JOHNSON. Senator Collins.

Senator COLLINS. Thank you very much, Mr. Chairman.

Mr. Secretary, it's good to see you again. I want to add my thanks to those of my colleagues for your briefing us in your office and introducing the new members of this subcommittee to the important work and your priorities.

Doctor, I want to follow up on questions that Senator Hoeven asked you about suicides in the military and among our veterans. And I'm very concerned about the epidemic of suicides.

I know that a 2012 VA report on suicide data that was based on information from 21 States found that an estimated 22 veterans lose their lives to suicide each day. And we know in addition that, last year, there were approximately 350 military suicides as well.

Obviously, these data are alarming and tragic. I listened very carefully as you went through the list of what the VA is doing. And I commend you for the focus.

OVERMEDICATION

But the fact is, there is substantial evidence that prescription-drug abuse is a major contributing factor in both military Active Duty and veterans' suicides.

And it is for that reason that in July of last year, I wrote to the Attorney General and asked that he use the authority that Congress had provided him by the Secure and Responsible Drug Disposal Act of 2010 to allow military and VA treatment facilities to conduct controlled-substance take-back programs. These have occurred in my State with considerable success.

It's my understanding that the Drug Enforcement Administration, the DEA, recently proposed new regulations to expand the options available to collect controlled substances. And by this, I'm talking about unused prescriptions, for example. That's probably the most common example.

But the regulations, much to my dismay, failed to authorize VA and DOD pharmacies, medical facilities, or medical personnel, to take part in appropriate drug take-back programs. So I'm introducing a bipartisan bill that will require the Attorney General to work with the VA, with Secretary Shinseki, and with the Secretary of Defense, to implement drug take-back programs.

I'm interested in your assessment, whether you would support the VA being involved, and able to directly take back these drugs, and thus mitigate the possibility of abuse of them ending up on the black market, or being given to another veteran who has mental-health problems, and perhaps leading to very tragic results.

Secretary SHINSEKI. Senator, I tell you, I'm in great agreement with you here on drug abuse. Even within the VA, I've asked a question of ourselves, do we overmedicate people, and then, so what happens with the drugs?

We are now part of the State monitoring system for prescription writing. I think this take-back policy you're describing just makes sense with everything else we're doing.

I think prescription drugs continue to show up as a part of the problem when we deal with lots of other issues. So we're happy to work with you on this.

Senator COLLINS. Thank you. I think this is absolutely critical and really could make a difference. And I'm particularly concerned when our Active Duty military leave and go back home, and they may have these very powerful prescriptions, and very little follow-up, which brings me to another issue.

One of you mentioned the fact that 41 percent of total enrolled veterans reside in either rural or highly rural areas of our country. And of course, that certainly describes much of the State of Maine.

PROJECT ARCH

And we know that providing access to care is one of the VA's top priority objectives, and that you're especially focusing on those 3.4 million rural veterans who are enrolled in the VA system. There is a 3-year VA pilot project that is known as Project ARCH.

One of the sites happens to be in my hometown of Caribou, Maine. It has been an extraordinary success. The veterans that use that program absolutely give it very high approval ratings.

They can get the care they need without traveling far to get it. The one VA hospital in Maine, for example, is 4 hours away from my hometown of Caribou.

And I believe that in your budget, you cited this pilot project, the Project ARCH program, as one of your accomplishments, and rightly so, based on what I've seen.

So this allows veterans in rural and highly rural areas to receive specialty care closer to home from community healthcare providers, which also helps with that continuity problem that we were discussing earlier with the turnover at VA facilities, instead of being forced to drive hundreds of miles to the nearest VA hospital, for example.

So my question is, given the success of Project ARCH, do you intend to extend this program beyond fiscal year 2014?

Dr. PETZEL. Well, Senator Collins, thank you very much for the kind words. We have also been very pleased with it, particularly the way it has worked in Maine. The arrangements with the Cary Medical Center really have been excellent.

We're in the third year of Project ARCH. It's a 5-year pilot study being done at five sites. I think that we would probably hold our cards for a bit yet to see what the evaluation, once we're deeply into the pilot, is of the four sites around the country.

Certainly, if it proves to be a successful concept, we would want to extend this beyond those five pilot sites. But I think the evaluation needs to be done. We've got at least another year or two before we do that.

Senator COLLINS. Well, I would say that I think the preliminary indications are that you've got a real winner. And I would invite any of you to come to the program in northern Maine at any time, if you want to see it.

It is an extremely successful program. And Maine has a very high rate of veterans in its population, and I feel so good about the fact that in the middle of the winter, we're not forcing these vet-

erans to have to travel long distances to get the specialty care that they need. They can get it right at the local hospital.

So it's been a great program, and it saves travel time and money as well. So I hope they're all as successful as the one at Cary Memorial Hospital in Caribou, Maine.

Thank you.

Senator JOHNSON. Secretary Shinseki, I again thank you and your colleagues for appearing before this subcommittee, and I look forward to working with you this year.

We will convene panel two momentarily.

Mr. Griffin, please come forward.

OFFICE OF INSPECTOR GENERAL

STATEMENT OF RICHARD J. GRIFFIN, DEPUTY INSPECTOR GENERAL

ACCOMPANIED BY:

JOHN DAVID DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS

LINDA HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS

Senator JOHNSON. Mr. Griffin, I welcome you to this hearing. This is the first time we have had the VA Inspector General's Office (OIG) testify on the budget. And I thank Chairwoman Mikulski for suggesting it.

In an agency as large and complex as the VA, your office plays a unique and crucial role in ensuring that the VA delivers the quality care and service that our vets depend on, and that the agency's resources are properly managed and accounted for.

In reviewing the fiscal year 2014 budget submission, I see that quality of care, management of regional office operations, disability claims workloads, and effective oversight of information technology programs and projects, are listed among your major management challenges.

I'm also concerned about a report your office issued earlier this week regarding mismanagement of the contract mental health program at the Atlanta VA Medical Center. According to the report, the lack of effective patient care management and program oversight by the facility contributed to problems with access to mental healthcare and contributed to patients falling through the cracks.

As you know, this is not an abstract problem. Of the three cases cited in the report, two vets committed suicide and one was incarcerated due to the facility's failure to ensure continuity of care.

Due to the surge in mental health issues among recent vets and the efforts at increased funding that this subcommittee has supported to improve access to mental healthcare, I worry that this is not an isolated incident.

Allowing vets with mental conditions to fall through the cracks is not acceptable. I'm interested in your thoughts on how contract mental health programs can be improved throughout the VA.

Thank you, Mr. Griffin. You may proceed. Please feel free to summarize your remarks. Your full statement will be included in the record.

SUMMARY STATEMENT OF RICHARD J. GRIFFIN

Mr. GRIFFIN. Thank you, Mr. Chairman, and thank you for the opportunity to discuss VA Office of Inspector General priorities in fiscal year 2014.

I'm accompanied by Ms. Linda Halliday, Assistant Inspector General for Audits and Evaluations, and Dr. John David Daigh, Assistant Inspector General for Healthcare Inspections.

In fiscal year 2012, the OIG issued 299 reports, and our oversight produced a 36-to-1 return on investment. This return is realized in terms of program savings, cost avoidance, questioned costs, and actual dollars recovered.

One of VA's core missions is to provide compensation benefits for those injured during their service in the military. The delivery of

these benefits is a major challenge for VA and our work indicates that much work continues to be needed in both technology initiatives and better training for staff to reduce the growing backlog of claims.

In February 2013, we issued a report on a Veterans Benefits Management System known as VBMS. We reported that even though VA had not fully tested VBMS, they continued to deploy it to the VA regional offices. The system had not been fully developed to the extent that its capability to process claims from initial application through review, rating, award, and, finally, to benefits delivery could be sufficiently evaluated. We note that the partial VBMS capability deployed to date has experienced system performance issues.

In addition, as of the VBMS report date, VBA did not have a detailed plan for scanning and digitization of veterans' claims, nor an analysis of requirements. In our recent inspections in January, March, and April of this year of the regional offices in Houston, Milwaukee, and Newark, 25 employees provided us a users' perspective of VBMS.

Generally, staff expressed frustration with the system because of spontaneous system shutdowns; latency issues related to slow times to download documents, such as medical evidence for review; longer times to review the electronic evidence; mislabeled electronic evidence; and mixing evidence from one veteran's electronic file to another veteran's file.

Given the incremental system development approach used and the complexity of the automation initiative, VA will continue to face extremely difficult challenges in meeting its goal of eliminating the backlog of disability claims processed by 2015.

As you referenced, in our full statement we have reported on a number of challenges confronting the Veterans Health Administration. Topics addressed include waiting times; access to mental healthcare; non-VA fee care, including fiscal controls; staffing standards; the VISN management structure; and women's health issues.

In reality, these are overlapping issues. Without accurate waiting times and productivity standards, it is difficult or impossible to know how many specialists you need for timely access to mental healthcare and women's healthcare. If there's more demand for VA care than VA providers can handle, you need proper management structure and focus at the VISNs and medical centers to direct the quality of care, as well as the fiscal oversight of the non-VA fee-basis programs.

At a time of unprecedented demand for VA benefits and service, the OIG has directed its oversight efforts on VA's most formidable challenges. We are committed to these efforts because it is both good Government and because it honors our Nation's commitment to those who served.

With increased attention to the areas outlined in our statement, we believe we can help ensure that veterans get the care, support, and recognition they've earned in service to our country.

PREPARED STATEMENT

Mr. Chairman, thank you for the opportunity to discuss the oversight work of the OIG, and we appreciate the continued, steadfast support and interest you and the subcommittee have demonstrated for our mission. We welcome any questions that you may have for us this afternoon.

[The statement follows:]

PREPARED STATEMENT OF RICHARD J. GRIFFIN

INTRODUCTION

Mr. Chairman and members of the subcommittee, thank you for the opportunity to discuss the Department of Veterans Affairs (VA) Office of Inspector General (OIG) priorities in fiscal year 2014. I will focus on recent OIG work in claims processing and access to healthcare because they continue to be challenges for VA. In addition, I will briefly cover OIG work in VA's other programs and operations. I am accompanied by Ms. Linda Halliday, Assistant Inspector General for Audits and Evaluations, and Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections.

In fiscal year 2012, the OIG issued 299 reports and our oversight produced a $36 to $1 return on investment;[1] as of March 31, 2013, we have issued 164 reports and realized a $33 to $1 return on investment. This return is realized by VA in terms of program savings, cost avoidance, questioned costs, and actual dollars recovered. The OIG's Office of Healthcare Inspections, whose mission results in improving the healthcare provided to veterans rather than saving dollars, is not included in the return on investment calculation.

VETERANS BENEFITS ADMINISTRATION (VBA)

One of VA's core missions is to provide compensation benefits for those injured during their service in the military. The delivery of these benefits is a major challenge for VA and our reports indicate that much work continues to be needed in both technology initiatives and better training for staff to reduce the growing backlog of claims.

VETERANS BENEFITS MANAGEMENT SYSTEM DEVELOPMENT

In February 2013, we issued a report on the Veterans Benefits Management System (VBMS)[2] that found VA had not fully tested VBMS yet continued to deploy it to VA regional offices. Due to the incremental development approach VA chose, the system had not been fully developed to the extent that its capability to process claims from initial application through review, rating, award, to benefits delivery could be sufficiently evaluated. However, we determined the partial VBMS capability deployed to date has experienced system performance issues. For example, on April 8, 2013, VBA performed an update to the portion of the VBMS system related to rating claims. As a result, the system was unexpectedly unavailable nationwide for 2 days.

As of the VBMS report date, VBA did not have a detailed plan for scanning and digitization of veterans' claims nor an analysis of requirements. We identified issues hindering VBA's efforts to convert hard-copy claims to electronic format for processing within VBMS, including disorganized electronic claims folders and inadequate management of hard-copy claims. As one of VBA's main transformation initiatives, the Under Secretary for Benefits indicated VBMS is designed to assist VA in eliminating the claims backlog. At the end of fiscal year 2010, VBA's inventory of pending claims was just over 530,000 that took an average of 166 days to complete; as of March 2013, VBA's inventory of pending claims had grown to over 850,000 and is now taking an average 292 days to complete.

In our more recent inspections of the VA regional offices (VAROs) in Houston, Texas; Newark, New Jersey; and Milwaukee, Wisconsin; 25 staff provided us a user's perspective of VBMS. Generally, staff expressed frustration with the system in part because of spontaneous system shutdowns, latency issues related to slow

[1] Office of Inspector General Department of Veterans Affairs Semiannual Report to Congress April 1, 2012—September 30, 2012.

[2] Review of VBA's Transition to a Paperless Claims Processing Environment (February 4, 2013).

times to download documents such as medical evidence for review, longer times to review the electronic evidence, mislabeled electronic evidence, and mixing evidence from one veteran's electronic file to another veteran's file.

Further, as outlined in our April 2013 report[3] we found that claims processing inaccuracy at the Baltimore, Maryland, VARO had more than doubled for the types of medical disability claims we reviewed since our first inspection in June 2009. The error rates changed from 28 percent inaccurate to 68 percent inaccurate for the claims we reviewed. VBA's Systematic Technical Accuracy Review (STAR)[4] of a cross section of all claims found the Baltimore VARO went from 76.8 percent accuracy in 2009, down to 74.4 percent in 2013. The inventory of pending claims grew significantly from 7,000 in 2009 and about 19,000 in 2013, while the staffing level only increased slightly from 134 staff to 143 staff respectively. The average days to complete disability claims went from 210 days in 2009 to 342 days in 2013.

Given the incremental system development approach used and the complexity of the automation initiative, VA will continue to face challenges in meeting its goal of eliminating the backlog of disability claims processing by 2015. We are continuing our oversight of VA's ongoing VBMS system development efforts assessing the system's functionality, costs, and ability to establish and meet schedule milestones.

TEMPORARY 100 DISABILITY EVALUATIONS

Our January 2011 report, Audit of 100 Percent Disability Evaluations, identified veterans receiving long-term payments to which they were not entitled. We projected that since January 1993 regional office staff overpaid veterans a net amount of about $943 million. Without timely corrective action, we conservatively projected that VBA would overpay veterans $1.1 billion over the period of calendar year 2011 through calendar year 2015. Over the last 3 years our VARO Inspections Program repeatedly reported systemic problems are continuing in VBA's processing of temporary 100 percent disability ratings. None of the 57 VAROs inspected fully followed VBA policy, which resulted in VARO staff not adequately processing temporary 100 percent ratings for approximately 66 percent of cases reviewed. These errors resulted in just under $17,000,000 in overpayments and almost $311,000 in underpayments.

In our inspections of three California VAROs,[5] we reported high errors rates, ranging from 53 to 97 percent, in processing temporary 100 percent disability evaluations. The magnitude of these and other claims processing errors caused VBA to temporarily cease operations at the Oakland and Los Angeles VAROs in order to provide training to staff.

In June 2011, and again in August 2012, VBA officials modified the electronic system to ensure suspense diary dates for medical re-examinations would automatically populate and remain in the system without manual entry. Currently, it appears these system corrections are working as we have observed that the diary dates remain in the system after being automatically populated. Although VBA has taken action to modify their electronic systems, these system fixes have not fully addressed the staff errors we frequently find. For example, during our fiscal year 2012 inspection cycle and through March 2013, where we reviewed 29 VAROs, 524 (62 percent) of the total 848 temporary 100 percent disability evaluations contained processing errors. Within this group of 524 errors, 338 (approximately 65 percent) were attributed to human error. These errors include staff not scheduling medical reexaminations after receiving reminder notifications to do so, or staff not following up to reduce the temporary evaluations after notifying veterans of their intent to do so.

MEDICAL EXAMINATIONS AND DISABILITY BENEFITS QUESTIONNAIRES

Our VARO inspections continue to find claims processing errors associated with the use of medical examinations that do not contain the required information to render sound disability determinations. Further, we identified 30 of the 365 disability benefits questionnaires (DBQs) that did not contain adequate information to make accurate disability determinations.

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[3] Inspection of VA Regional Office Baltimore, Maryland (April 11, 2013).

[4] STAR is a key mechanism for evaluating regional office performance in processing accurate benefit claims for veterans and beneficiaries. The STAR process provides a comprehensive review and analysis of compensation rating processing associated with specific claims or issues.

[5] Inspection of the VA Regional Office Los Angeles, California (May 10, 2012); Inspection of the VA Regional Office Oakland, California (May 10, 2012); Inspection of the VA Regional Office San Diego, California (May 10, 2012).

Our February 2012 report, Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires, reported VA began using DBQs in October 2010 as an initiative to help reduce the claims backlog. DBQs are condition-specific forms designed to capture medical information relevant to veterans' disability benefits claims. We reported that VA needed to strengthen internal controls over the use of DBQs in order to better prevent, detect, and minimize the risk of fraud and provide reasonable assurance that medical documentation used in the rating process is authentic and unaltered. Specifically, VBA had not developed adequate internal controls to ensure DBQs completed by private physicians were authentic and unaltered.

VETERANS HEALTH ADMINISTRATION (VHA)

For many years, the Veterans Health Administration (VHA) has been a national leader in the quality of care provided to patients when compared with other major U.S. healthcare providers. VHA's use of the electronic medical record, its National Patient Safety Program, and its commitment to use data to improve the quality of care has sustained VHA's quality of care performance. However, VHA faces particular challenges in managing its healthcare activities. The effectiveness of clinical care, budgeting, planning, and resource allocation are negatively affected due to the continued yearly uncertainty of the number of patients who will seek care from VA.

ACCESS TO MENTAL HEALTH SERVICES

The OIG conducted a review[6] at the request of the VA Secretary, Chairmen and Ranking Members of the U.S. Senate and U.S. House Committees on Veterans' Affairs, and the Chairman and Ranking Member of the House Veterans' Affairs Committee's Subcommittee on Health, after they expressed concerns that veterans may not be able to access the mental healthcare they need in a timely manner. In response, OIG reported VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental healthcare services.

VHA did not provide first-time patients with timely mental health evaluations, and existing patients often waited more than 14 days past their desired date of care for their treatment appointments. In fiscal year 2011, VHA had reported 95 percent of first-time patients received a full mental health evaluation within 14 days. Using the same data VHA used to calculate the 95 percent success rate, we selected a statistical sample of completed evaluations to review which supported only 49 percent of these evaluations occurred within 14 days. In fact, on average, for the remaining patients, it took VHA about 50 days to provide them with their full evaluations. Further, we reported approximately 1.2 million or 12 percent of patient follow-up appointments exceeded 14 days. We concluded that a series of timeliness and treatment engagement measures could provide decisionmakers with a more comprehensive view of the ability with which new patients can access mental health treatment. We offered recommendations to the Under Secretary for Health to revise the full mental health evaluation measure to ensure the measurement is calculated to reflect a veterans' actual wait time experience.

This week we released two reports on the mental healthcare program at the Atlanta VA Medical Center in Decatur, Georgia. The first[7] was focused on allegations of an inpatient's death due to mental health service leadership's negligence and mismanagement of unit policies, patient monitoring, staffing, and lack of caring about patients. We did not substantiate the allegations of inadequate staffing, inappropriate staff assignments, or that leadership did not care about patients. However, we substantiated that the facility did not have adequate policies or practices for patient monitoring, contraband, visitation, and urine drug screening. We found inadequate program oversight including a lack of timely follow-up actions by leadership in response to patient incidents.

We recommended that the Under Secretary for Health ensure that VHA develops national policies to address contraband, visitation, urine drug screening, and escort services for inpatient mental health units. We also recommended that the Veterans Integrated Service Network (VISN) and facility directors ensure that the inpatient mental health unit develops these policies; strengthen program oversight and follow-up; improve communication with staff; and ensure functional and well-maintained life support equipment.

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[6] Review of Veterans' Access to Mental Health Care (April 23, 2012).

[7] Healthcare Inspection—Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia (April 17, 2013).

The second report[8] assessed the allegations of mismanagement and lack of oversight of a mental health contract. We substantiated mismanagement in the administration of the contract, and also substantiated additional allegations that there was inadequate coordination, monitoring, and staffing for oversight of contracted mental health patient care. Facility managers did not provide adequate staff, training, resources, support, and guidance for effective oversight of the contracted mental health program. Mental health service line managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety.

The facility referred patients to the Community Service Boards (CSBs) for several years before they started to track the patients referred. The facility estimated that they referred between 4,000 and 5,000 patients since 2010, but did not know the status of those patients. The facility managers were aware that a large number of patients were, in the words of employees, "falling through the cracks" and estimated that the Mental Health Assessment Team continued to refer up to 60 new patients each week to the CSBs.

We reviewed 85 electronic health records from a list received from the facility of CSB-referred patients. We found that 21 percent of our random sample of CSB-referred patients were never provided care by the CSBs, with no follow up provided by the facility. VHA requires that an initial mental health appointment be scheduled within 14 days of referral. The contract did not have a time requirement, but only stated that the expectation was patients would be seen as soon as possible. We found that patients waited an average of 19 days for their initial assessment (range from 1 to 80 days). Seventy-four percent of CSB-referred patients had wait times greater than 14 days, with a wait time average of 92 days and a median range of 56 days (range from 5 to 432 days).

We recommended that the Under Secretary for Health rectify the deficiencies described in this report with respect to the provision of quality mental healthcare and contract management, with the goal that veterans receive the highest quality medical care from either the VA or its partners. The Under Secretary for Health and the VISN and facility directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

These reports are particularly troublesome because in July 2011, we reported[9] on problems with the management of the electronic wait list for several mental health clinics at the same facility. Among the findings of that report, we substantiated that several mental health clinics had significantly high numbers of patients on their electronic wait lists over a period of months in fiscal year 2010, and we substantiated that facility managers were aware of the wait lists but were slow in taking actions to address the condition. Large mental health electronic wait lists are inherently problematic as they represent impaired access to critically needed care.

These new findings stand in contrast to our findings[10] in March 2009 regarding mental healthcare for veterans in Montana. In that report, we found that VA leverages community resources, VA resources, and fee care to provide mental healthcare for rural veterans.

NON-VA FEE CARE PROGRAMS

The OIG has reported that VHA faced significant challenges to address serious nationwide weaknesses in its Non-VA Inpatient and Outpatient Fee Care Programs.[11] Specifically, our audits disclosed serious weaknesses in the pre-authorization of fee service. The cost of fee care rose from $1.6 billion in fiscal year 2005 to almost $4.3 billion in 2013. As early as 2009, we reported that VHA improperly paid 37 percent of outpatient fee claims resulting in $225 million in overpayments and

[8] Healthcare Inspection—Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia (April 17, 2013).

[9] Healthcare Inspection—Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia (July 12, 2011).

[10] Healthcare Inspection—Access to VA Mental Health Care for Montana Veterans (March 31, 2009).

[11] Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program (August 3, 2009); Audit of Non-VA Inpatient Fee Care Program (August 18, 2010); Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program (June 8, 2010); Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System (November 8, 2011); Administrative Investigation—Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado (April 12, 2012); and Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations (August 20, 2012).

$52 million in underpayments. We estimated $1.1 billion in overpayments and $260 million in underpayments over the next 5-year period if VHA did not strengthen its processes for authorizing fee care services. In fiscal year 2010, we reported that VHA improperly paid 28 percent of inpatient fee claims resulting in net overpayments of $120 million and estimated $600 million in improper payments could be processed over the next 5-year period. Weak authorization procedures resulted in VA healthcare facilities not having reasonable assurance that requests for services are medically necessary.

Approximately 5 years have passed since we issued our first report on the fee care program, yet we continue to have concerns that the authorization of fee care services is still too weak to ensure sufficient funds for these services are available to pay for the services veterans receive. In January 2013, our review[12] of the South Texas Veterans Healthcare Systems' management of fee care funds substantiated an allegation that the healthcare system authorized $29 million in fee care without sufficient funds to pay for the services received by veterans. We found management at the South Texas Healthcare System and the VISN lacked effective oversight mechanisms to ensure the financial management and stewardship of these funds.

In response to our August 2010 audit of Non-VA Inpatient Fee Care Program, VHA and OIG agreed there will be general cost-savings and efficiencies realized with consolidating the fee program's claims processing system to achieve better economies of scale. Although specific cost-savings depend on the actual consolidated strategy VA selects and on how well VA implements the chosen strategy, we conservatively estimated that current program inefficiencies cost VHA about $26.8 million in fiscal year 2009, and could cost about $134 million over the next 5 years. We recommended the Under Secretary for Health evaluate alternative payment processing options to identify mechanisms to improve payment processing costs and timeliness. Today, we do not see VHA moving forward with an actual consolidation strategy for payment processing in the fee care program.

PHYSICIAN STAFFING STANDARDS FOR SPECIALTY CARE SERVICES

In December 2012, we issued a report on VHA's Physician Staffing Levels for Specialty Care Services. We found VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. The need for VHA to develop a staffing methodology is not a recent issue. As early as 1981, we recommended that VHA develop a methodology to measure physician productivity. VHA has not established productivity standards for 31 of 33 specialty care services we reviewed, and VA medical facility management did not develop adequate staffing plans. VHA's lack of productivity standards and staffing plans limit the ability of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs.

To determine an approximate measure of current physician specialty productivity, we established a rudimentary standard by identifying VHA's relative value unit median for each specialty care service. The national median is the middle value among each specialty care service. Using that median, we analyzed the collective group of specialty physicians at all medical facilities and determined that 12 percent of physician full-time equivalents did not perform to the standard, and represented $221 million in physician salaries during fiscal year 2011. Although we did not analyze the productivity of individual physicians, our results support the need for an in-depth evaluation of staffing. The primary message of this report is that VHA needs to implement productivity standards to measure and compare the collective productivity of physicians within a specialty care service at VA medical facilities. This information is necessary and fundamental to planning and building appropriate budgets to meet veteran's needs and ensuring timely access to care.

WOMEN'S HEALTH ISSUES

VA must provide care to a growing number of women veterans, currently 10 percent of the veteran population. In fiscal year 2009, VA spent $180 million on gender-specific medical care. In fiscal year 2014, the President's budget plans on spending $422 million, a change of approximately 134 percent from fiscal year 2009.

In December 2012,[13] we issued a report on VHA services available to women veterans who have experienced military sexual trauma (MST). We conducted the review at the request of the Senate Committee on Veterans' Affairs. VHA policy states

[12] Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds (January 10, 2013).

[13] Healthcare Inspection—Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma (December 5, 2012).

that veterans and eligible individuals who report experiences of MST, but who are deemed ineligible for other VA healthcare benefits or enrollment, may be provided MST-related care only. VHA also requires that veterans and eligible individuals must have access to residential or inpatient programs able to provide specialized MST-related mental healthcare, when clinically needed, for conditions resulting from MST. VHA requires that all facilities screen veterans for MST.

We reviewed inpatient and residential programs identified by VHA as resources for female veterans who have experienced military sexual trauma. We conducted site visits and reviewed the electronic health records of female veterans with MST discharged from these programs between October 1, 2011, and March 31, 2012. We found:

—Nearly all the women in our review had more than one mental health diagnosis. Ninety-six percent were diagnosed with PTSD. Major depression and substance use disorders were also common. Almost 90 percent of the women in the review were receiving outpatient mental health services in the 3 months prior to admission to the inpatient or residential program.

—Gender-specific care and same gender therapists were available. Treatments utilized varied by site, but all programs employed one or more evidence-based psychotherapies.

—Women were often admitted to programs outside their VISN. Some of these veterans travel across the country to VA residential programs that consider themselves national resources. Obtaining authorization for travel funding was frequently cited as a problem for patients and staff. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. This is not aligned with the MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

—We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

In a report[14] from December 2010 on VA healthcare and compensation benefits for combat stress in women veterans, we found:

—Female veterans generally were more likely to transition to and continue to use VA healthcare services.

—Higher proportions of female veterans generally were diagnosed with mental health conditions by VA after separation, but lower proportions were diagnosed with post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI).

—Higher proportions of female veterans generally were receiving disability benefits for mental health conditions, but a lower proportion for PTSD and TBI.

—Gender-based biases were not identified in VBA's adjudication of male and female disability claims, but data limitations affect a full assessment of some outcomes.

—VBA has guidance and training for evaluating MST claims, but sensitivity training is needed for claims processors and women veterans coordinators.

—VBA has not assessed the feasibility of requiring MST-specific training and testing.

PROSTHETICS MANAGEMENT

As a result of our oversight reports,[15] VHA acknowledged that improvements in prosthetics inventory management are necessary. In March 2012, we reported VHA needs to strengthen VA Medical Center (VAMC) management of prosthetic supply inventories to avoid spending funds on excess supplies and to minimize risks related to supply shortages. We estimated during April through October 2011 that VAMCs maintained inventories of approximately 93,000 specific prosthetic items worth about $70 million. Further, we estimated that VAMC inventories exceeded current needs for almost 43,500 items (47 percent) and were too low for nearly 10,000 items (11 percent).

VHA cannot accurately account for these inventories and because inventory management practices are weak, inventory losses associated with diversion can go undetected at VAMCs. To avoid spending taxpayer dollars on excess prosthetic supply

[14] Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits (December 16, 2010).

[15] Audit of VHA Acquisition and Management of Prosthetic Limbs (March 8, 2012); Audit of VHA's Prosthetics Supply Inventory Management (March 30, 2012).

inventories and risking the disruption of patient care by experiencing supply shortages, VHA must ensure VAMCs properly manage prosthetic inventories. By strengthening VAMC management of prosthetic supply inventories and using supplies stocked in excess inventories instead of purchasing additional supplies, VHA can reduce prosthetic supply costs by approximately $35.5 million. VA cannot afford to use valuable financial resources to purchase, maintain, and store more prosthetic supplies than necessary. In response to our work, VHA now has a plan to replace its inventory systems with a comprehensive inventory management system. Completion of the new system is projected for fiscal year 2015, pending the availability of funds.

In addition to the management of prosthetics, we conducted a review [16] to evaluate VA's capacity to deliver prosthetic care. We assessed VA credentialing requirements for prosthetists and orthotists; the demand for healthcare services; and psychosocial adjustments and activity limitations of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans with amputations and their satisfaction with VA prosthetic services. We found:

—All required prosthetist and orthotist staff in VA regional amputation centers and polytrauma amputation network sites and all their prosthetic laboratories were certified.

—Veterans with amputations are a complex population with a variety of medical conditions and are significant users of VA healthcare services and not just prosthetic services.

—OEF/OIF/OND veterans with amputations were generally adapting to living with their amputations. While some veterans reported receiving excellent care at VA facilities, many veterans indicated that VA needed to improve care. Concerns with VA prosthetic services were centered on the VA approval process for fee basis or VA contract care, prosthetic expertise, and difficulty with accessing VA services.

VETERANS INTEGRATED SERVICE NETWORK (VISN) MANAGEMENT

In March 2012,[17] OIG assessed Veterans Integrated Service Network (VISN) office management controls and fiscal operations to determine if funds and resources, accountability and transparency, effective oversight of VHA healthcare facilities, were in compliance with VA policies. Since their establishment 16 years ago, the VISN organizational office expenses had increased over 500 percent above the original estimates. OIG reported VISN offices lacked adequate financial controls and accurate information for areas such as travel, leased office space, and performance awards. The growth in operational costs and the fiscal issues identified supported that VHA needed to strengthen VISN office financial management and fiscal controls. VHA lacked fundamental management controls and quality data needed to ensure that VISN offices effectively and efficiently use staffing resources that might otherwise be used for direct patient care.

The Under Secretary for Health agreed with the findings and recommendations and put plans in place to establish a more uniform organizational structure. VHA established work teams to analyze the VISN office operations and to address the VISN offices' lack of a clear consistent definition of purpose that links to a standard structure and function capability. VHA now has agreement on a clear plan to streamline and standardize VISN organizational structure and staffing and is in the process of implementing this plan for more effective oversight of its healthcare facilities and related community-based outpatient clinics, nursing homes, and veterans' centers.

VETERANS INTEGRATED SERVICE NETWORK PROCUREMENT PRACTICES

Since fiscal year 2000, the OIG has identified procurement practices as a major management challenge. VA made major changes intended to strengthen its procurement process including establishing an integrated oversight process that replaced traditional, technical, and legal reviews. In a review of VISN contracts,[18] the OIG assessed whether VHA implemented the new controls effectively and provided the oversight and resources needed to ensure VISN contracting officers award and manage contracts in accordance with acquisition laws, regulations, and VA policy. We reported that required integrated oversight reviews were not conducted on about 68

[16] Healthcare Inspection—Prosthetic Limb Care in VA Facilities (March 8, 2012).

[17] Audit of VHA's Management Control Structures for Veterans Integrated Service Network Offices (March 27, 2012); Audit of VHA's Financial Management and Fiscal Controls for Veterans Integrated Service Network Offices (March 27, 2012).

[18] Audit of VHA's Veterans Integrated System Network Contracts (December 1, 2011).

percent of contracts, when required. In fact, we estimated almost 3,000 contracts valued at just under $1.6 billion were at risk because systemic contracting deficiencies associated with acquisition planning, contract award, and administration were not effectively addressed.

VETERAN HOMELESSNESS

In November 2009, the VA Secretary announced a goal to end homelessness among veterans by 2015. OIG performed an audit [19] to determine whether community agencies receiving funds from the Grant and Per Diem Program are providing services to homeless veterans as agreed upon in their grant agreements in fiscal year 2012. Further, we examined whether program funding was effectively aligned with program priorities. This program provides transitional housing for homeless veterans through partnerships with nonprofit and local government agencies. Serious female veterans' housing, safety, security, and privacy issues were discovered during the course of our audit that required immediate management attention by VHA.

We reported the placement of homeless females in a male-only approved provider facility. The seriousness of the issues supported a need for VHA to perform a nationwide assessment to identify other inappropriate housing situations placing veterans at risk under the grant program. VHA officials took immediate action to conduct an inventory to ascertain the gender-mix identified in each funded grant proposal and the appropriateness of the services available relative to the veterans currently served. Housing situations were assessed to better ensure the privacy, safety and security of homeless veterans. We also reported VHA lacked an effective mechanism to assess and measure bed capacity, procedures to monitor the liability of reported information, and sufficient training on program eligibility. A weak grant application process created uncertainties on the abilities of some providers to deliver the supportive services described in their grant proposals. To minimize the risks to homeless veterans in this program, VHA agreed to implement standards to ensure providers have the capability and mechanisms to deliver proposed services to homeless veterans prior to awarding grant funds.

VA CONFERENCES

In September 2012,[20] OIG reported that VA processes and oversight were too weak, ineffective, and in some instances non-existent, to ensure conference costs were accurate, appropriate, necessary, and reasonably priced. Simply put, accountability and controls were inadequate to ensure effective management and reporting of dollars spent for two human resources conferences. We questioned about $762,000 as unauthorized, unnecessary, and/or wasteful expenses. More than a year after the conferences, VA was unable to provide an accurate and complete accounting of costs associated with two of its conferences. Further, significant expenditures were authorized by VA staff lacking authority to make the purchases, resulting in unauthorized commitments. Transparency was lacking for what services VA purchased and paid for. Sound conference management processes and practices were needed to gain assurance that future business could be conducted in an economical manner in order to ensure proper fiscal stewardship of taxpayer funds. This work is important since VA conference spending had reached almost $100 million annually.

OFFICE OF INSPECTOR GENERAL (OIG) INVESTIGATIVE WORK

From April 1, 2012, through March 31, 2013, the Office of Investigations opened 1,028 and closed 1,046 investigations, arrested 493 individuals for a wide variety of criminal offenses, and completed judicial actions resulting in more than $1.8 billion in fines, penalties, restitutions, and civil judgments.

SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS PROGRAM

We arrested 13 individuals who defrauded VA's Service-Disabled Veteran-Owned Small Business Program. Those sentenced during this timeframe received 142 months' imprisonment and were ordered to pay $8.7 million in fines, restitution, and forfeiture. Additionally, the 13 individuals and companies involved have been referred to the VA committee for suspension and debarment. During this timeframe,

[19] Audit of VHA's Homeless Providers Grant and Per Diem Program (March 12, 2012); VHA's Safety, Security, and Privacy for Female Veterans at a Chicago, Illinois, Homeless Grant Provider Facility (September 6, 2011).

[20] Administrative Investigation of the fiscal year 2011 Human Resources Conferences in Orlando, Florida (September 30, 2012).

seven individuals and four companies were suspended, and four individuals and one company were debarred from contracting with other Federal agencies.

FIDUCIARY FRAUD

We arrested 19 individuals who stole money from VA beneficiaries who were not competent to handle their financial affairs. In addition to the 266 months' imprisonment imposed this past year, restitution ordered exceeded $3.5 million.

THREATS AND ASSAULTS

The OIG received 561 threat referrals, resulting in 57 full investigations. We open a referral on every threat allegation that is reported by VA, VA police service, or others. The vast majority involve preliminary investigations that normally include an interview of the subject and results in the subject admitting that they were not serious about the threat and were only trying to get VA to act on their particular issue. Full investigative cases are opened for cases that involve the arrest, involuntary committal, or result in a substantial amount of investigative work. These full investigations resulted in 36 arrests. Although many threat referrals do not result in judicial action, we take all threats against VA employees and VA property seriously.

We also conducted 35 non-sexual assault investigations resulting in 27 arrests, and 25 sexual assault investigations resulting in 11 arrests. These involved veteran assaults on VA employees, VA employee assaults on veterans, employee on employee assaults, and veteran on veteran assaults.

BENEFICIARY TRAVEL FRAUD

We recently prioritized the deterrence of fraud associated with VA's beneficiary travel reimbursement program, which was funded at approximately $861 million in fiscal year 2012. Typically, this type of fraud involves veterans grossly inflating the number of miles driven to and from VA facilities by providing a false home address on the claim form. During the last 12 months, we conducted 201 of these investigations, resulting in the arrest of 63 individuals. In each of these prosecutions, we encouraged prosecutors to issue press releases to deter this type of fraud. In addition to developing our own data analytic tool to proactively identify potential fraud, we have worked closely with VHA program officials to significantly enhance their data mining efforts and design new warning posters to be placed where veterans file claims.

NEW OIG INITIATIVES

We are currently performing an audit to assess whether VHA is effectively managing purchased home care services to ensure veterans receive appropriate services.

OIG's current work in VHA includes examining the management of hearing aids, as hearing loss is the most common service-connected disability. We are also assessing whether VHA is effectively managing the allocation of Home Telehealth Program funds to improve access to care and to reduce patient treatment. Work in VBA includes projects that are examining the accuracy and timeliness of GI Bill payments and assessing the effectiveness of VBA's processing of Quick Start Claims. While it is too early to report results on the GI Bill project, our preliminary results support that the processing of Quick Start Program claims is taking longer to process than the average time for all disability claims. In addition, our preliminary results are that VBA needs to improve the Quick Start claims-processing accuracy rate.

As President Obama's administration has placed emphasis on reducing spending on management support service contracts, we are examining if VHA ensured support service contract requirements were justified, and assessing how well contract performance is monitored. As we continue to focus our efforts to help VA improve the weaknesses in contract awards and administration, we have teams examining whether the Technology Acquisition Center (TAC) is effectively awarding and administering information technology service contracts. From October 2010 to June 2012, the TAC awarded almost 4,475 contracts valued at $8.8 billion. We also have two active projects reviewing purchase card activity. One project is identifying opportunities for VHA to realize savings annually by leveraging purchase card use while the other project is examining the extent that VA personnel are making unauthorized commitments using purchase cards. Lastly, we plan follow-up work to assess the effectiveness of VA's controls over conference management expenditures, to determine whether VA is demonstrating effective controls in spending.

CONCLUSION

At a time of unprecedented demand for VA benefits and service, the OIG has directed its oversight efforts on VA's most formidable challenges, including disability claims processing and mental healthcare. We will continue to provide VA with recommendations on how to improve benefits and services to veterans, and the information technology, financial, and acquisition systems that support VBA and VHA's delivery of these services. We are committed to these efforts both because it is good government and because it honors our Nation's commitment to those who served. With increased attention to the areas outlined in this statement, we believe that VA can improve performance, achieve savings, and reduce risks.

Mr. Chairman, thank you for the opportunity to discuss the results of the work of the OIG. We appreciate the continued steadfast support and interest you and the subcommittee have demonstrated for our mission. We welcome any questions that you or other members of the subcommittee may have.

BACKLOG OF CLAIMS

Senator JOHNSON. Mr. Griffin, the VA's strategy to breaking the claims logjam is pinned on successfully developing and deploying VBMS. Deployment of this paperless system to all regional offices is scheduled for June 2013.

In February, the inspector general issued a report on VBMS and found that the VA had not fully tested the system. However, the Department continued with the deployment.

Moreover, I've been told that as recently as last week, the system was experiencing performance problems. This is very concerning, to say the least.

What has the inspector general found in its investigations? And are you planning any follow-up reports on this issue?

Mr. GRIFFIN. I would say that the deployment of VBMS at the regional offices that it has been sent to is not necessarily an indication that the system is 100 percent operable and ready to perform. I know that VBA would tell you the same thing, that there are multiple new initiatives that are being rolled out simultaneously, and it's being done at a time when they're facing massive new claims from post-9/11 veterans, from veterans who are aging, veterans who qualified for newly identified agent orange diagnoses and benefits, et cetera.

So they do have a steep climb, but there's not one silver bullet that's going to make this thing right. There are a whole series of different initiatives that are being rolled out all at once, and it's going to be a tough task to try and have everything work just perfectly in order to meet the 2015 goal.

Now as far as this follow up work, if I may, Linda Halliday, who oversees our audit staff, as I mentioned, has a team that is going to continue to monitor VBMS deployment. And she has another team that is doing inspections of all the regional offices on a 3-year cycle. So I would ask her if she would like to add anything.

Senator JOHNSON. Please.

Ms. HALLIDAY. We are looking at the system, the functional requirements that are being developed, to see if there is any gap in those, looking at the viability of the project schedule, looking at things like the expected transaction volume response time and whether the system really can produce accurate results.

Right now, VBMS has really processed about 4,000 claims. Not all of those claims were processed through the VBM system completely, because some went through as the pilots and the staff

doing some of the claims toggled back and relied on legacy systems when they had some system performance issues.

But VBA is moving forward, and we will look at both the production and the system viability and the risks in that scheduled deployment. We will also look at the accuracy of claims.

Senator JOHNSON. Mr. Griffin or Ms. Halliday, does your office believe that the 2015 goal is achievable?

Mr. GRIFFIN. Mr. Chairman, everyone who has attended this hearing today would love for that to be an accurate prediction. But is that January 2015? Or is that December 2015?

Senator JOHNSON. That the VA can——

Mr. GRIFFIN. That's a year apart. So I think it's a stretch goal in the face of the number of different initiatives that are being brought to bear simultaneously.

And as Madam Chairman indicated, there's a certain amount of training that's going to be required in order to make the switch from the old legacy systems to VBMS.

And as expected, what we have found is that it's causing the process to be slower now. That was acknowledged up front, but that's the reality.

So 2015 would take a great coming together of a number of issues, and I think it's really a stretch goal.

Senator JOHNSON. Mr. Griffin, as I mentioned in my statement, I'm concerned that shortfalls in monitoring mental healthcare patients being treated by outside contractors could be more widespread than just one facility.

Does the inspector general's office plan to conduct spot audits of any other VA medical centers, particularly those in densely populated urban areas, to assess whether the problems found at the Atlanta Medical Center are potentially widespread?

ACCESS TO VA MEDICAL CARE

Mr. GRIFFIN. I will give you a preliminary response, and I want to ask Dr. Daigh to also weigh in on this issue. We did do an audit on wait times in mental health about 1 year ago. We found that the methodology that was being utilized to determine wait times was not one that we found to meet VA's own standard. We issued a report about that, and we received comments back from the Department.

We get about 30,000 hotline contacts a year in our organization. It covers the full range of activities. A lot of them involve claims. A lot of them will involve access.

Frankly, the point that Senator Collins brought up about excessive medications and the resulting outcomes, which we've witnessed in the form of sexual assault and regular assault, and threats on VA employees, veteran-on-veteran threats and veteran-on-employee threats, are a byproduct of that same issue. So it is a very important issue.

Dr. Daigh's people go to every medical center in the country on a 3-year cycle. They identify what we think to be the most critical areas to look at, and certainly mental health is on their radar. So I would ask Dr. Daigh if he would expound upon that.

Senator JOHNSON. Dr. Daigh.

Dr. DAIGH. Yes, sir.

I would say that the breakdown that we found in Atlanta was probably best described as an inability to coordinate and monitor the care of veterans. Because VA Atlanta was overwhelmed with mental healthcare demand, they had to send to outside providers for treatment.

So it's fairly common for me to find, through usually hotline work, that VA has a very difficult time managing care that they procure either through what they call their fee-basis program or, in this case, where they had contracts with these community mental health providers.

I should say that in a prior report looking at Montana, we found the actual opposite result. We found that in Montana several years ago, VA had a very good alliance with local mental healthcare providers, to a great impact in a positive way on delivery of mental healthcare services to veterans.

I think that VA needs to say to themselves that we're responsible for all the veterans, not just those who are enrolled at our facility. And if you start with that mindset, then when you think about the veterans who are in your region, and you realize that travel time is an issue, it forces you to look at the provision of care locally, like Project ARCH, which I'm only minimally familiar with. But ARCH works well reflects the kind of coordination that I think VA needs to work on more.

So there is a system of community mental health providers and clinics that vary State-to-State and sometimes county-to-county. But in order to be effective, VA has to have a way to pay efficiently and pay a reasonable price for the care. They have to have a way to get the medical record the VA has electronically into the hands of the provider they'd like to see this patient. And they have to wait then to receive information on the care provided.

So if you simply say, here's a chit for fee basis, go get care, that doesn't work very well.

And in Atlanta, again, the failure for the business practices of the contract, and then the clinical practices of ensuring that the proper information went with the veteran to a provider, and that information was received, was really totally broken.

So we've seen it work, and, unfortunately, I've seen it fail more than I've seen it work.

Senator JOHNSON. Senator Begich.

Senator BEGICH. Mr. Chairman, thank you very much. I just have a couple questions.

Thank you all for being here.

ANCHORAGE VA REGIONAL OFFICE INSPECTION

You all did an inspector general report for Alaska. VA showed an error rate, and I'm just curious if you could expand on that, and what you saw was maybe a significant issue there, or was it multiple issues?

Could you help me there on the error rate disability claims? As you probably saw in the authorizing committee a few weeks ago, I got a little animated on this issue, because it was somewhat amazing to me.

And for such a—I want to say a closed environment—and Alaska's not complicated. We're not having people leave State, come

back to States. You know, they're there. It's not a complicated thing.

And so, first, I want to say, thank you for doing the report, because without your report, I'm not sure we would have known the depth of this issue, and the impact it's having on Alaskans. And it's also a little piece of the bigger issue of disability claims.

Can you just give me a sense of where those problems are? And then, do you feel that they are moving forward at a decent rate of correcting these errors or these issues?

And I'll give you one comment here, and that is, as a former mayor, we had an internal auditor. I always liked when our Department said, after the audit, they all said, "We agree with their conclusions," and blah, blah, blah. And then a year later, I find out my department hasn't done one damn thing.

So can you give me the assurance I need that they're actually doing and following up on the issues you've brought forward?

I didn't mean to give you a lot there, but this one is a big issue, as you know.

Ms. HALLIDAY. Well, we did our first benefits inspections in 2009. And at that time, we went in and we looked at four different medical type ratings. The Anchorage VARO had an error rate at that point of 29 percent for that group of claims.

TEMPORARY 100 PERCENT RATINGS

The second time, in January 2013, we went in and looked at temporary 100 percent disability evaluations and traumatic brain injury, and just those two areas, because we were clearly focusing on some of the financial risks associated with inaccuracies there.

Senator BEGICH. Very good.

Ms. HALLIDAY. The error rate had gone up to 47 percent. We were concerned that——

Senator BEGICH. Can I pause you there for a second?

In your 2009 report, did you not have not only notification of the problem, but suggestions or recommendations, or at least areas of concern that they should focus on?

Ms. HALLIDAY. Yes, we did.

Senator BEGICH. Is that a fair statement?

Ms. HALLIDAY. Yes.

Senator BEGICH. Did they not do that?

Now, remember, you're the inspector general. You get to say what we need you to say to make sure we're trying to figure this out. Because it sounds like—I mean, that's 4 years—for 3 years. Let's say 3, because 2013 isn't completed.

Help me understand. You give them a list, and tell them 29, or whatever the percent is. Three years later, you take two of the subsets. And they, I don't want to say double, but pretty sizable increase in errors. So something didn't happen, or maybe not as aggressively as it could have. Help me here.

Mr. GRIFFIN. Let me step back a little bit on the process that we use, because VBA has their own process, called STAR, wherein they evaluate accuracy in their claims processing. That's the number that when they're saying in 2015 they'd like to get to 98——

Senator BEGICH. Percent fulfillment and so forth.

Mr. GRIFFIN. Right. Accuracy.

Senator BEGICH. Right.

Mr. GRIFFIN. When we, with the resources we have available, go into a regional office to look at the claims that were done there, if someone is a double amputee, that's one of those express lane type cases, there's no—I mean, that's a slam-dunk. This is 100 percent, and you're done with it.

Senator BEGICH. Right.

Mr. GRIFFIN. We change from one cycle to the next what we think we need to look at. So in 2009, the types of claims we looked at, we gave them specific recommendations, and they agreed to fix those.

When we went back——

Senator BEGICH. But did they?

Mr. GRIFFIN [continuing]. We had different ones.

Senator BEGICH. So do you not then, on those that they agreed to fix, how do you know——

Mr. GRIFFIN. We will check. We do follow-up. We have a separate unit that when we put recommendations out——

Senator BEGICH. Okay, but it's 3 years.

Mr. GRIFFIN [continuing]. They say we will fix this by a date certain.

Senator BEGICH. Did they give you dates that are now past due?

Mr. GRIFFIN. Yes, that's in our report. In the 2009 report, when they concur, they will say, completion date of *x.*

Senator BEGICH. Okay, understood. I don't have 2009 sitting in front of me.

Mr. GRIFFIN. Right. I know, but just from a process perspective.

Senator BEGICH. Sure. Okay.

Mr. GRIFFIN. We will keep that report open until we're satisfied that the issue has been fixed.

Senator BEGICH. Is that report still open?

Mr. GRIFFIN. I don't have it in front of me, either.

Senator BEGICH. Okay.

Mr. GRIFFIN. We will let you know about that and the subsequent report.

[The information follows:]

The 2009 report on the Inspection of the VA Regional Office Anchorage, Alaska, contained 12 recommendations. We closed our report on June 17, 2010, which means that the VA Regional Office provided information on actions they implemented that we believed would address all of our recommendations. The most recent inspection report released in January 2013, contains six recommendations and all remain open as of the date of the hearing.

Mr. GRIFFIN. So you have to realize, when we review these temporary 100 percent claims, after 18 months, when you're a temporary 100 percent claim, there has to be a follow-up medical exam to see if you still deserve 100 percent.

Senator BEGICH. Understood.

Mr. GRIFFIN. So if that medical exam doesn't happen, and there are a number of reasons why it wasn't happening, one being that in some instances there was a problem in the software, and even if it was put in, it was dropping out of the system.

Senator BEGICH. Understood. Okay.

Mr. GRIFFIN. But we've looked at the universe of all of them, in an audit from January 2011, and we concluded after that audit

that over 5 years, if this wasn't fixed, it was going to cost $1.1 billion.

Senator BEGICH. In this office?

Mr. GRIFFIN. No, nationwide.

Ms. HALLIDAY. Nationwide.

Senator BEGICH. Nationwide, okay. You almost gave me a heart attack there.

Mr. GRIFFIN. And we did the Baltimore office weeks ago. We issued that report. They had an 83 percent error rate in the temporary 100 percenters.

So if it's $200 million a year, we're 2 years and 3 months past the date of that national audit.

And now the computer glitch is supposed to have been addressed, but that just deals with future cases. The ones that we identified as needing to be reviewed to make sure that if it had fallen out, that it's reinserted, we're still waiting for proof that that's all been done.

Senator BEGICH. Let me ask this, and then I'll ask, Mr. Chairman, if it's okay, I do have a couple other questions, but I'll submit those for the record.

But here's what I want to be able to know and be able to understand, because this is very frustrating to me, because being on the appropriations side and being on the authorizing side, it's kind of an interesting story, you might say.

So you do the audits. You make recommendations. You follow that up through a separate office. You keep the audit open until those items are satisfied, I mean those things they said were going to be done, are done.

And then you take another step to make sure what they said they were going do is done, and producing the results, in theory, right, to lower the error rate. Would that be the theory? What you recommend should lower the error rate. Is that right?

Mr. GRIFFIN. Yes.

Senator BEGICH. Okay. But do you take that last and final step and give maybe here or to the authorizing committee, because here's my biggest frustration around this place here. It's almost like, 3 years from now, we'll have the same discussion, because everyone does their reports and everyone says that you bet, we will concur. And then they kind of concur, but maybe not as robust as we said, and then they'll tell us we didn't have enough money to do it. And then you do another audit. And then we say, why don't you do some more?

So is there a process that we see actually you go and you audit. They say they do this. You say they've completed it. And, oh, by the way, now there are results, because the result you just give me, it's going the wrong way, even though it's a subset. I recognize that. They are apples and oranges, to a degree.

But if they're having problems in this, I would put money on it, they're having problems elsewhere. I'm just doing an educated guess, not a data-driven.

Is that a fair statement or am I way off here?

Mr. GRIFFIN. It is fair, but what is not fair is the apples and oranges part.

The 2009 review looked at different areas. As I said, it would make no sense for us to invest time and resources to look at something that is a slam-dunk. And you're not going to get it——

Senator BEGICH. I agree.

Mr. GRIFFIN. TBI is tough.

Senator BEGICH. I agree.

Mr. GRIFFIN. PTSD is tough.

Senator BEGICH. Right.

Mr. GRIFFIN. Gee, is this, 100 percent, 50 percent, 20 percent or none? And it's a very difficult process.

The physical injuries are a slam-dunk, and those should be expedited. TBI is tough. This temporary 100 percenter has just been something that, you know, has taken too long to get fixed.

In further answer to your question, when her team goes back in 2012 to look at what's going on now, they will have looked at the 2009 report. They will see, yes, they said they'd fix these things. And while they're there, they will satisfy themselves that they did.

The same thing with Dr. Daigh's personnel that are going to the medical centers on a 3-year cycle. If they were in the medical center in Chicago at Hines 3 years ago and gave them 10 things or 5 things that they thought needed to be addressed, we would track those through follow-up.

It would be too intensive to go back every time. So show me your policy, show me how you did it.

But then when his people go back 3 years later, they will make sure of it.

Senator BEGICH. Look at the outcome. Very good. Thank you.

Thank you, Mr. Chairman. I didn't mean to go on there, but I think disability claims is a common thread among us all here, and to understand this process is, I think, helpful for all of us.

Thank you very much.

Senator JOHNSON. Thank you for your testimony, Mr. Griffin and colleagues. And thank you for your work on behalf of the VA and the Nation's vets.

ADDITIONAL COMMITTEE QUESTIONS

For the information of members, questions for the record should be submitted by the close of business on April 26.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO HON. ERIC K. SHINSEKI

QUESTIONS SUBMITTED BY SENATOR TIM JOHNSON

INTEGRATED ELECTRONIC HEALTH RECORD (IEHR)

Question. Secretary Shinseki, the budget includes $344 million for the integrated Electronic Health Record. The subcommittee has been very supportive of this joint VA–DOD effort. However, there are questions about the future and direction of this program.

Can you please explain to us what has changed since last year and what direction the iEHR is taking in 2013?

Answer. To be clear, VA and the Department of Defense (DOD) are not moving away from the goal of a single, joint, integrated Electronic Health Record—both Secretary Shinseki and Secretary Panetta reaffirmed the Departments' commitment to this in public statements on February 5th. What has changed is the strategy that

we will use to accomplish that goal. The revised program strategy includes a shift in focus to "quick win" interoperability accelerators and a shift in strategy from "buy, adopt, create" to "adopt, buy, create," which will reduce risk and cost, while also accelerating the delivery of capability to users. As part of this strategy to get the compatibility sooner, the Departments will define a "core" set of integrated Electronic Health Record (iEHR) capabilities that will allow us to evaluate the selection of existing Electronic Health Record (EHR) products to reduce program risks and costs while accelerating implementation. VA has committed to deploying an iEHR core based on VistA. DOD is currently in the process of evaluating options, including both VistA and commercially available products, for its core system. All of these efforts are focused on meeting the key dates of Initial Operating Capability (IOC) in 2014 and Full Operating Capability (FOC) in 2017.

As well as renewing our commitment to IOC and FOC, VA, and DOD added a focus this year on accelerators. First, VA and DOD clinical health data will be made available in near real-time using translation mechanisms such as the Health Data Dictionary and DOD's adoption of Blue Button. This data interoperability work will be completed by January 2014. Second, the Secretaries approved deployment of the presentation software called JANUS Graphical User Interface (GUI) to five VA polytrauma rehabilitation centers and two associated Military Treatment Facilities by July 31, 2013. JANUS is the tool clinicians use to view VA and DOD health data simultaneously. Third, the Departments will create a VA–DOD Medical Community of Interest network and security infrastructure to enable the creation of a logical "single medical enclave" that meets both Departments' security requirements, provides equal access to iEHR services by both Departments, leverages existing DOD and VA existing infrastructure, and provides connectivity between DOD and VA medical networks. This is scheduled to be accomplished by November 2013. Fourth, the Departments will rapidly adopt an identity management solution to establish consistent methods for identifying and retrieving persons across the two organizations. This is scheduled to be completed by December 31, 2013.

Question. And, what will this change mean in terms of the overall cost of the program and timeline for deployment?

Answer. While the original budget estimate in 2011 projected a development and deployment budget of $4–$6 billion, this estimate was conducted using analogous work based on the requirements and architecture known at that early stage. The Interagency Program Office (IPO) developed a bottom-up Life Cycle Cost Estimate (LCCE) in September 2012. This LCCE was nearly double the budget estimate that was made when the program was just beginning. The development of LCCE was required as part of the Milestone B approval process, a part of DOD's acquisition process and the process adopted across the broader iEHR Program. While VA agrees with the methodology used to develop the new LCCE, VA is still working with IPO to adjust LCCE to reflect the significantly lower costs seen by VA as a result of fully embracing the Program Management Accountability System.

We believe costs will be driven down by the decision to accelerate data interoperability capabilities, the shift in strategy to select a minimal core set of capabilities from an existing EHR system as the foundation of iEHR, the adjustment of the business rule to "adopt, buy, create," and institutionalizing the delivery of customer-facing software in increments of 6-months or less.

The timeline for deployment has not changed. The Departments are committed to meeting IOC in 2014 and FOC in 2017.

BOARD OF VETERANS APPEALS

Question. Mr. Secretary, the average time to resolve an appeal before the Board of Veterans Appeals is currently approaching 2 years, and the backlog of claims is growing, from more than 39,000 claims in 2012 to a projected level of more than 65,000 claims in 2013—close to double. At the same time, staffing at the BVA has been steadily decreasing. At my direction, the fiscal year 2013 MILCON–VA bill included an additional $8 million above the budget request for additional personnel at the BVA.

What is the current staffing plan for the BVA, and what steps is the VA taking to address this unacceptable backlog of claims before the BVA?

Answer. As noted in the chairman's annual report, in fiscal year 2012 the average time to resolve an appeal before the Board of Veterans' Appeals (BVA or Board) from physical receipt of the case at BVA to issuance of a BVA decision was 251 days. This includes the Board's cycle time of 117 days. Cycle time measures the time from when an appeal is physically received at the Board until a decision is reached, excluding the time the case is with a Veterans Service Organization (VSO) representative for preparation of the written argument. Notably, the appeals process

is bifurcated with most of the appeals processing steps taking place at the VA Regional Office (RO) level and the final appeals adjudication taking place at the Board level. Specifically, when the RO issues a decision with which the veteran disagrees, the veteran can initiate an appeal at the RO by filing a Notice of Disagreement (NOD). After that point, the RO issues a second decision known as a Statement of the Case (SOC). In fiscal year 2012, the average number of days between the RO's receipt of an NOD and the issuance of an SOC was 270 days. Following the SOC, if a veteran wishes to formalize the appeal, the veteran must file a substantive appeal (VA form 9). After that point, the RO can certify and send the appeal to the Board for a final decision.

BVA has commenced an aggressive hiring plan to execute the $8 million additional funding provided in the Consolidated and Further Continuing Appropriations Act of 2013. In order to complete this hiring effort, BVA has obtained the necessary Human Resources (HR) support by signing a memorandum of understanding with the Veterans Health Administration's HR staff. The Board has also assessed its critical needs by position type and has updated its Spend Plan accordingly. Additionally, the Board is in the process of surveying existing office space, equipment and training needs to accommodate the increase in Full Time Employees (FTE). Finally, in order to recruit the requisite staff, BVA has ongoing job announcements open.

As a result of these efforts, BVA expects to on-board approximately 25 attorneys in the next month. The Board is reviewing and interviewing additional applicants on an ongoing basis, and will continue to hire attorney staff for the remaining 4 months of fiscal year 2013 to execute the additional funding. There is a direct and proportional correlation between the number of BVA employees and the number of decisions produced per year, with an average of 90 decisions produced per FTE. With the $8 million increase, BVA will be able to hire approximately 55 FTE (all attorneys), thus resulting in an additional 4,950 decisions produced per fiscal year once they are fully trained.

In addition to pursuing this aggressive hiring plan, to address BVA's growing pending inventory of appeals, the Board is also actively engaged in efforts to increase efficiencies in the appeals process. In particular, BVA has increased Video Teleconference (VTC) hearings, which allows BVA judges to reduce travel for hearings, and, thus, remain in the office and leverage the down time to work cases when an appellant fails to appear for a hearing. VBA and BVA have also partnered on a Joint Training Initiative to reduce remands to the field and the resulting rework that is required when BVA remands to VBA. Additionally, BVA is pursuing a Lean Six Sigma study of the BVA decision-writing process to find efficiencies to increase decision output. BVA is also leveraging technology to further streamline operations, to include use of a virtual docket that allows for efficient electronic management of BVA hearings, and virtualization of hearing transcripts and mail processes, thereby eliminating delay caused by adding paper copies to claims folders. Finally, BVA has set forth a number of legislative proposals that seek to streamline the adjudicatory process. These include: (1) allowing BVA more flexibility in scheduling VTC hearings in order to minimize travel time and expenses related to conducting in-person hearings in the field; (2) reducing the time period to initiate an appeal with an NOD from 1 year to 180 days; (3) clarifying that a timely filed Substantive Appeal (VA form 9) is a jurisdictional requirement for BVA review; (4) simplifying the content requirements of BVA decisions, making them more understandable to veterans; and (5) changing Equal Access to Justice Act (EAJA) fee requirements to better focus attorney energy at the Court of Appeals for Veterans Claims (CAVC) on achieving improved results for veterans.

LEASES

Question. Mr. Secretary, as you are aware, the Congressional Budget Office has changed the way in which it scores VA medical facility leases. This change has effectively made leasing medical facilities nearly impossible because of Government accounting rules. This inside the beltway accounting practice has already prevented 15 new medical facilities from opening.

What contingency plans will the Department be instituting to ensure that VA clinics are accessible to vets should these scoring practices continue?

Answer. If the leases requiring authorization do not receive authorization, VHA will need to execute multiple, smaller leases to meet the projected demand for the existing services. This will ensure patients do not face increased wait times, deficient parking, and cramped space to accommodate the anticipated increases in workload. Unfortunately, this will create inefficiency with duplication of staff and logistics at multiple sites, a lack of continuum of care for veterans in having dif-

ferent facilities providing various services, and increased costs to contract care to ensure services are provided closer to the veteran.

Question. And are current leased facilities in danger of closing when the lease is up for renewal?

Answer. Eight leased facilities are in danger of closing, including five clinical and three research and administrative. They currently require authorization to renew their current size.

MENTAL HEALTH INSPECTOR GENERAL REPORT AND CONTINUITY OF CARE

Question. Mr. Secretary, the VA inspector general's office recently released a report regarding mismanagement of the contract mental healthcare program at the Atlanta VA Medical Center. Alarming as that report was, I am concerned that the problem may not be limited to only one facility. Increasing access to mental healthcare has been a priority of this subcommittee as we have seen the staggering statistics on PTSD, Traumatic Brain Injury (TBI), substance abuse and other mental health conditions among the Iraq and Afghanistan vets. And most troubling, as we have seen a spike in suicides among veterans of these wars.

The inspector general reported that a lack of program oversight and patient care management allowed thousands of patients to "fall through the cracks." Sadly, some of those patients committed suicide. A lack of adequate funding and staffing were cited as contributing to the problems at the Atlanta hospital.

What is the VA doing nationwide to ensure that mental healthcare patients are receiving the continuity of care they need, and that contract mental health programs are being effectively monitored?

Answer. VA has developed a quality improvement process to confirm that facilities are implementing the required services and programs for mental health to ensure veterans receive high-quality mental healthcare. In fiscal year 2012, VA conducted site visits at all 140 VA Health Care Systems to review implementation status of the required mental health programs. Mental health site visitors, trained in the standardized site visit protocol, were experienced field-based mental health leaders and staff and mental health subject matter experts from the Office of Mental Health Operations, Mental Health Services, Veteran Integrated Service Network (VISN) leadership, and Office of Homeless Programs. Site visitors spoke not only with facility leadership but also frontline mental health staff, veterans, and families. The site visitors served as consultants to support facilities to improve areas that were noted to be challenging. Following the visit, the facilities were also asked to develop and submit action plans for ongoing improvement in areas needing improved quality, including improvements in continuity of care. VA is working with the facilities to monitor these improvement efforts and to make additional changes if required.

In fiscal year 2013, the Veterans Health Administration (VHA) Mental Health began identifying VA medical centers interested in initiating community contracts to address local mental health access problems. VHA Mental Health and medical centers involved in this workgroup are collectively developing examples of effective quality of care requirements and processes in contracting for mental health services. The products will be made available for all VA facilities or VISNs who are seeking community contracts.

BLACK HILLS HEALTH CARE SYSTEM (BHHCS)

Question. Federal law requires the VA to protect, use, and preserve its historic resources; consider multiple alternatives to proposed undertakings; solicit and consider public input; and take into account the effects of the VA's proposed changes to National Historic Landmarks. Can you describe how the VA has fulfilled each of these requirements in relation to any potential changes in services that may be proposed at the Hot Springs, South Dakota, facility?

Answer. In May 2012, as required by the National Historic Preservation Act of 1966 (NHPA), VA initiated formal consultation with the South Dakota State Historic Preservation Office, the National Park Service, and other consulting parties, regarding proposals to reconfigure the VA Black Hills Health Care System (VA BHHCS). VA continues to identify and evaluate a range of alternatives for providing veterans with safe, quality healthcare services, while also assessing, in collaboration with other stakeholders, potential effects to historic properties these alternatives may have. Any recommended reconfiguration of VA BHHCS services that has the potential to adversely affect the Hot Springs campus or other historic properties will continue to be the subject of NHPA consultation, as well as National Environmental Policy Act analyses, to address such effects through avoidance, reduction, or mitigation. Stakeholder input collected by VA will be evaluated as part of the ongoing processes in accordance with Federal law.

Question. VA's performance and accountability report for 2012 states that the agency is using the space it owns or directly leases by 116 percent (page II–83); in other words, it is in an overutilization condition. As a result, the agency's leased space costs have risen to $608 million in 2012 (page III–52). Yet the agency stewards an inventory of at least 850 buildings and structures that are unused or underutilized, some of which are in Hot Springs. How are these assets accounted for in the VA's space utilization consideration and performance reporting? Are they removed from the equation and, if so, why?

Answer. VA's capital inventory includes all buildings at all facilities nationwide, including the "underutilized" buildings at Hot Springs. While it is true that VA is in an "overutilization" state by 16 percent nationally, the demographics and utilization figures have wide variance related to specific market conditions, veteran demographics, and service needs. The Hot Springs campus currently indicates an excess of space because of the decreasing workload at that facility caused by the declining veteran population. This has resulted in the underutilized buildings at the Hot Springs campus.

QUESTIONS SUBMITTED BY SENATOR MARK L. PRYOR

MENTAL HEALTHCARE PROFESSIONALS

Question. In August 2012, the President issued an Executive order on "Improving Access to Mental Health Service for Veterans, Servicemembers, and Military Families." One of the President's directives was to expand the Department of Veterans Affairs mental health services staff. Specifically, the VA was directed to hire 1,600 mental health professionals by June 30, 2013, and to hire and train 800 peer to peer counselors.

In late March, it was reported that 1,089 mental health professionals had been hired and that the Department was confident it would reach its target by the end of June.

Please comment on the specific qualifications of these mental healthcare professionals. For example, do they range from certified counselors and therapists, to psychologists with a master's or higher degree?

Answer. Basic requirements for all mental health positions include U.S. citizenship (however, non-citizens may be appointed when it is not possible to recruit qualified citizens) and the following requirements:

—*Licensed Professional Mental Health Counselor.*—Hold a master's degree in mental health counseling, or a related field, from a program accredited by the Council on Accreditation of Counseling and Related Educational Programs and hold a full, current, and unrestricted license to independently practice mental health counseling, which includes diagnosis and treatment.

—*Marriage and Family Therapist (MFT)—Education.*—Hold a master's degree in marriage and family therapy from a program approved by the Commission on Accreditation for Marriage and Family Therapy Education or have graduated from a nationally accredited program conferring a comparable mental health degree as specified in the qualification standards of those disciplines (social work, psychiatric nursing, psychology, and psychiatry). All additional course work taken to be accepted for MFT licensure must come from a nationally accredited program in one of the above areas and hold a full, current, and unrestricted license to independently practice marriage and family therapy in a State.

—*Social Worker—Education.*—Hold a master's degree in social work from a school of social work fully accredited by the Council on Social Work Education. Graduates of schools of social work that are in candidacy status do not meet this requirement until the school of social work is fully accredited. A doctoral degree in social work may not be substituted for the master's degree in social work. Furthermore, applicants must hold a current, full, active, and unrestricted license or certification by a State to independently practice social work at the master's degree level.

—*Nurse (Registered Nurse)—Education.*—Graduate of a school of professional nursing approved by the appropriate State agency and accredited by one of the following accrediting bodies at the time the program was completed by the applicant: The National League for Nursing Accrediting Commission or The Commission on Collegiate Nursing Education, an accrediting arm of the American Association of Colleges of Nursing. Applicants must hold a current, full, active and unrestricted registration as a graduate professional nurse in a State, territory, or Commonwealth of the United States (e.g., Puerto Rico), or the District of Columbia.

—*Psychologist—Education.*—Hold doctoral degree in psychology from a graduate program in psychology accredited by the American Psychological Association (APA). Successfully completed a professional psychology internship training program that has been accredited by APA and hold a full, current, and unrestricted license to practice psychology at the doctoral level in a State, territory, Commonwealth of the United States (e.g., Puerto Rico), or the District of Columbia.

—*Physician—Education.*—Degree of doctor of medicine or an equivalent degree resulting from a course of education in medicine or osteopathic medicine. The degree must have been obtained from one of the schools approved by the Secretary of Veterans Affairs for the year in which the course of study was completed. Approved schools are: (1) schools of medicine holding regular institutional membership in the Association of American Medical Colleges for the year in which the degree was granted; (2) schools of osteopathic medicine approved by the American Osteopathic Association for the year in which the degree was granted; and (3) schools (including foreign schools) accepted by the licensing body of a State, territory, or Commonwealth (e.g., Puerto Rico), or the District of Columbia as qualifying for full or unrestricted licensure and hold a current, full, and unrestricted license to practice medicine or surgery in a State, territory, Commonwealth of the United States, or the District of Columbia.

Question. What method does the VA use to determine how many mental healthcare professionals are needed to service the veteran population? Is there a ratio of providers to veterans?

Answer. VA has developed staffing guidance for general outpatient mental health teams based on identifying staffing requirements per 1,000 veterans. VA is currently developing similar guidance for specialty outpatient mental health teams. The factors considered in developing these models include:

—veteran population in the service area;

—mental health needs of veterans in that population; and

—range and complexity of mental health services provided in the service area.

This guidance is still being evaluated based on access, veteran and provider satisfaction, quality of care, and provider productivity to ensure the staffing guidance ensures access to high-quality veterans' care.

Question. How is the VA identifying the rural veteran population, and ensuring they have access to the same level of care?

Answer. VA has the same staffing requirements for rural veterans as it does for urban veterans. However, VA has multiple innovative strategies for ensuring staffing requirements for rural veteran are met including the use of contract care, the use of telemental health, and specialized healthcare delivery and transportation programs specifically designed to meet the unique access needs of rural veterans. The VA Office of Rural Health (ORH) addresses mental health needs of rural veterans by funding targeted projects submitted by field personnel and other related program offices in response to a request for proposals that is announced each year. Mental health, homelessness, provider training on mental health issues, and rural clinic mental health staffing support are always high priorities for ORH. Each application submitted is peer-reviewed for how well the proposed intervention or program addresses the identified need. Local needs assessments are conducted as part of the proposal preparation process. Typically, the proposals will include information as to the number of rural veterans potentially impacted, the prevalence of mental health disorders in the local population, and a geographic gap analysis of services. In fiscal year 2013, ORH funded 61 projects across 20 VISNs totaling $21.8 million that included support for the following mental health related projects.

FISCAL YEAR 2013 ORH MENTAL HEALTH FUNDED PROJECTS

VISN	Project name	Funding
V01	Chronic Pain Treatment Project	$226,011
V01	Mental Health Rural Pilots	400,000
V01, V03, V06, V21, V23	Rural Health Training and Education Initiative	1,112,077
V02	Behavioral Health Expansion in the Tompkins/Cortland County Rural Areas	250,000
V02	Depression Medication Monitor Case-Finding Outreach Program for Rural Veterans	213,328
V02	Equine Therapy for Rural Veterans	20,000
V02	Veteran Rural Health Medical and Psychological Resource and Services Center	515,278
V05	Enhance Rural Access Network for Growth Enhancement (E–RANGE) for Eastern Shore	366,473
V05	Women's Health, Education and Training in Rural Areas, Mental Behavioral Health	476,791
V06	Albemarle Primary Outpatient Clinic Includes Mental Health	1,761,697

FISCAL YEAR 2013 ORH MENTAL HEALTH FUNDED PROJECTS—Continued

VISN	Project name	Funding
V06	Building Communities: Planning for a National Roll-Out of Rural Clergy Training	106,599
V06	Emporia CBOC Includes Mental Health Services	1,660,000
V06	Greenbrier County CBOC Includes Mental Health Services	1,687,304
V06	Robeson County Mental Health Community Outreach Program	28,441
V06	Staunton CBOC, Wytheville CBOC, and Lynchburg CBOC Telemental Health Include Mental Health Services	299,450
V06	Tazewell Telemental Health	146,888
V06	Educating Rural Clergy	180,707
V07	Public Psychiatry Fellowship	20,000
V07	Telephone Assisted Dementia Outreach	175,693
V07	Substance Use Disorders (SUD) and Post Traumatic Stress Disorder (PTSD) Services at CBOCs	710,815
V07	Supported Employment for Rural Veterans with Post Traumatic Stress Disorder (PTSD)	235,088
V08	Mental Health Intensive Case Management	287,057
V10	Expansion of Non-Drug Chronic Pain Treatment	41,000
V10	Mental Health Intensive Case Management Team	176,346
V10	Telemental Health Services	197,000
V12	Hancock CBOC Enhance Rural Access Network for Growth Enhancement Team (E–RANGE)	344,000
V12	Integrated Primary Care Mental Health Program for Rural Community Based Outpatient Clinics	860,671
V12	Rhinelander CBOC Enhance Rural Access Network for Growth Enhancement Team (E–RANGE) Team	195,000
V16	Enhance Rural Access Network Growth Enhancement (E–RANGE)	303,957
V16	Relaxation Training and Self-Management of Pain	81,240
V16	South Central Mental Illness Research Education & Clinical Center (SC MIRECC) Clergy-Mental Health Partnership to Improve Care for Rural Veterans	458,291
V17	Central TX Telemental Health Expansion Domiciliary	120,000
V17	Harlingen Outpatient Clinic Enhance Rural Access Network for Growth Enhancement Team (E–RANGE) Team Program	360,000
V17	Telemental Health Virtual Care Clinic	289,790
V17	Telepsychiatry within Central Texas Veterans Health Care System Project Expansion	494,000
V17	VISN-Wide Telemental Health Clinic for Underserved Rural Veterans	150,000
V18	CBOC Show Low/Globe Includes Mental Health Services	804,441
V18	Enhance Mental Health Services and Post Traumatic Stress Disorder Outreach for Rural Veterans on the Navajo/Hopi Nation	164,700
V18	Enhance Mental Health Services for Rural Veterans at the Northern Arizona VA Health Care System CBOCs	260,000
V18	Post-Traumatic Stress Disorder (PTSD) Awareness Training/Collaboration with Indian Health Services	40,000
V19	Mental Health Rural Pilots	271,339
V19	Telepain Treatment	305,909
V19	Sheridan VA Medical Center Challenge Course Enhancement	5,800
V19	Rural Native Veteran Telehealth Collaborative Education & Consultation	102,433
V2	Depression Medication Monitor Case-Finding Outreach Program for Rural Veterans	213,328
V20	Alaska Rural Native Telebehavioral Health Development	131,500
V20	Oregon Rural Mental Health Initiative	1,804,620
V20	Mental Health Rural Pilots	200,000
V20	Sustainment of Mountain Home Outreach Clinic	485,800
V20	Veteran Cycling for Health & Wellness	134,128
V21	Extension of Kauai CBOC Mental Health Services to North/West Kauai	207,187
V21	Extension of Kona CBOC Primary Care and Mental Health Services to North and South Areas of the Big Island	197,800
V21	Home-Based Telemental Health (HBTMH) for Pacific Region Rural Veterans Requiring Post Traumatic Stress Disorder Follow-up	282,382
V21	Treatment for Veterans and Family Members	106,766
V23	Fargo Mental Health Intensive Case Management (MHICM)	336,000
V23	Mental Health Rural Outreach—Max J. Beilke (Alexandria) CBOC	89,982
V23	Telemental Health Connectivity with Good Samaritan Hospital	134,000
V23	Rural Mental Health and Social Work Services	151,200
V23	Telemental Health Care of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans at Western Illinois University—Macomb Campus	132,278

FISCAL YEAR 2013 ORH MENTAL HEALTH FUNDED PROJECTS—Continued

VISN	Project name	Funding
V23	Addressing Rural Veteran Barriers to Mental Health Care Using Web-based Screening, Tailored Education, and Direct Outreach	176,884
V23	Evaluation of a Permanent Housing Model for Homeless Rural Veterans: The Lodge Project Phase 2	104,788
	TOTAL	21,794,257

Question. Please describe and discuss the peer to peer counselor initiative and any current results from the program, or expected impact once fully implemented.

Answer. Pursuant to Public Law 110–387, Public Law 111–163, and the August 31, 2012, Executive order titled "Improving Access to Mental Health Service for Veterans, Service Members, and Military Families," VHA's Office of Mental Health Services is implementing and expanding peer support services nationwide. By the end of December 2013, VHA expects to have 800 peer specialists and peer apprentices deployed among each VA medical center and each very large community-based outpatient clinic (CBOC). As a condition of employment, peers working in VHA must be certified to provide peer support services. VA has contracted with a not-for-profit community agency to provide the peer certification training at no cost to the peer. Peer specialists provide services adjunctive to the services provided by degreed professionals and are placed in a variety of mental health programs. Peer specialists promote recovery by sharing their own recovery stories, providing encouragement, instilling a sense of hope, and teaching skills to veterans.

It is too early in the expansion of peer support to provide clinical outcomes from the program. However, there have been studies of peer support from non-VA settings as well as from the early, initial implementation of peer support in VHA. The VA studies show that peers influenced veterans' involvement in their own care and increased veterans' social relationships. Other studies have shown several benefits from peer support, including a decrease in the use of inpatient mental health facilities, greater satisfaction and quality of life, greater hopefulness, better treatment engagement, and better social functioning. We expect similar results from the implementation of peer support services nationwide.

2012 SUICIDE DATA REPORT

Question. This February the VA released a comprehensive report on veterans who die by suicide.

In Mr. Petzel's response to the 2012 Suicide Data Report he outlined four immediate actions the Department must take. Action No. 1 stipulated that he receive a full report with "risk identification strategies and patient-centered focused care options" no later than March 1, 2013. Has this report been created, and can you speak to its findings?

Answer. A task group was chartered to address how to move mental healthcare to a more patient-centered care approach for the five highest risk groups including veterans with post-traumatic stress disorder (PTSD), sleep disorders, chronic pain, substance use disorders, and depression. A plan for addressing this issue was submitted to Robert Petzel, M.D., Under Secretary for Health, who approved moving ahead with the implementation strategy. Templates for care for these groups are being developed as well as a communication plan to assist in the culture shifts that will be required to fully implement this strategy within mental health.

Question. Regarding Action No. 4, can you please discuss the VA–DOD Joint Suicide Repository in terms of what data is included, and how that data will enable the VA's suicide intervention strategy?

Answer. The suicide data repository will hold death and suicide attempt information from both the Department of Defense (DOD) and VA. Joint data purchases have been made from the Centers for Disease Control and Prevention to obtain any death records available for anyone who has served in the military since 1979. Also included in the repository will be internal VA and DOD databases that include current suicide attempt and completion data. Looking at this data from a combined, broad perspective will allow us to identify more specific risk factors about military and post-military individuals including, but not limited to, risk information related to: discharge timeframes, job categories, deployments, service branch and job categories, medical diagnosis, medication use, etc. Knowing which and when veterans are at risk will allow targeted education and outreach strategies as well as enhanced care at critical periods.

Question. In addition to the Joint Suicide Repository, how are the VA and DOD working together to address suicide prevention techniques?

Answer. VA and DOD have a long history of working together in suicide prevention. Annual joint educational conferences are held to share current research findings and care-related strategies. The Veterans Crisis Line/Chat/and Text Service connects veterans in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline, online chat, or text. It also serves as the Military Crisis Line and provides all the same services to Active Duty servicemembers both in country and abroad. There are toll-free options to call from Europe, Korea, and the Middle East. The VA–DOD Joint Clinical Practice Guidelines have been developed and are in the review process. Education and awareness programs and materials are freely shared between the two departments. VA is also an active member of the DOD Suicide Prevention and Risk Reduction Committee.

VETERANS HOMELESSNESS

Question. In 2012 it is estimated that there were 62,619 homeless veterans on a single night in the United States (Annual Homeless Assessment Report (AHAR) prepared by HUD). While this is a significant decline since 2009, veteran homelessness remains a significant issue, one that my home State of Arkansas is working hard to address.

The President's budget request commits $1.4 billion towards programs which prevent or reduce veteran homelessness.

Can you comment on the types of community-based organizations the VA provides grants to, and measures of effectiveness that requires continued and increased funding?

Answer. VA's partnerships with community-based organizations provide the backbone to VA's efforts to end veteran homelessness. VA provides grants to consumer cooperatives, public, and nonprofit private community providers through the Grant and Per Diem (GPD) Program and the Supportive Services for Veteran Families (SSVF) Program. VA also partners with community-based organizations through its Health Care for Homeless Veterans (HCHV) Contract Residential Treatment Program.

GRANT AND PER DIEM (GPD) PROGRAM

Question. The GPD Program provides funding through grants to public (State and local governments and Indian tribal governments) and nonprofit private organizations to develop and operate transitional housing and supportive services for homeless veterans. The GPD Program currently has over 15,000 operational transitional housing beds in every State, the District of Columbia, Puerto Rico, and Guam. During fiscal year 2012, over 41,000 unique veterans received services from the GPD Program. This included over 2,800 women. Over 12,000 veterans exited the program to permanent housing in fiscal year 2012.

Answer. There is one 40-bed transitional housing GPD project in the State of Arkansas. The GPD Program in Arkansas provided services to 192 unique veterans in fiscal year 2012, including 20 women veterans, with 102 veterans exiting the program to permanent housing during that year.

For the past 20 years, the GPD Program has been a mainstay of VA's continuum of homeless programs. The GPD Program currently measures its success through a performance metric which has a target of 60 percent of homeless veterans exiting to an independent housing arrangement. Through April 2013, the GPD Program is at 64.55 percent for this performance measure, currently exceeding the target.

SUPPORTIVE SERVICES FOR VETERAN FAMILIES PROGRAM

Question. The SSVF Program provides supportive services grants to private nonprofit organizations and consumer cooperatives to coordinate or provide supportive services for very low-income veteran families. The SSVF Program is designed to rapidly re-house homeless veteran families and prevent homelessness for those at imminent risk of homelessness due to a housing crisis. In fiscal year 2012, SSVF awarded $100 million in funding to 151 community-based organizations serving veterans families in 49 States, the District of Columbia, and Puerto Rico. In 2013, the SSVF Program is expected to award nearly $300 million in supportive services grants.

Answer. St. Francis House based in Little Rock, Arkansas, is currently the one SSVF grantee in Arkansas. Through March 2013, St. Francis House has served 94 participants. Of the 94 participants, 76 participants have been discharged from SSVF with 73 participants (96 percent) being placed in permanent housing.

VA tracks performance of SSVF grantees through data collected in the Homeless Management Information System and VA's Homeless Registry. In fiscal year 2012, the first year of SSVF Program operations, community-based grantees assisted over 35,000 homeless and at-risk veteran families participating in the SSVF Program. This participation rate significantly exceeded VA's projected expectation to serve 22,000 in the first year of operation. In fiscal year 2012, the SSVF Program achieved significant success, with 86 percent of those exiting SSVF services either being placed or being able to maintain permanent housing.

HEALTH CARE FOR HOMELESS VETERANS CONTRACT RESIDENTIAL TREATMENT PROGRAM

Question. HCHV Contract Residential Treatment Program provides a gateway to VA and community supportive services for eligible veterans who are homeless. This includes ensuring that chronically homeless veterans and/or those with serious mental health diagnoses can be placed in community-based programs which provide quality housing and services that meet the needs of these special populations. Although VA's HCHV Contract Residential Treatment Program is not technically a grant program, local VA facilities offer competitive contract solicitations to community-based providers to provide contract residential treatment services and housing. Dedicated community partners are essential to the success of this program. During fiscal year 2012, HCHV provided funding for 3,287 beds through 299 contracted community providers in all 50 States, the District of Columbia, and Puerto Rico.

Answer. During fiscal year 2012, over 11,500 unique veterans received residential services from the HCHV Contract Residential Treatment Program. Over 3,800 veterans exited the program to permanent housing in fiscal year 2012. In Arkansas alone during fiscal year 2012, the HCHV Contract Residential Treatment Program provided residential services to 281 unique veterans and 112 veterans exited the program to permanent housing. There are currently 139 operational HCHV beds via six contracted community providers in the State of Arkansas.

VETERAN EDUCATION BENEFITS

Question. Since implementation of the Post-9/11 GI Bill, the VA has also implemented the Yellow Ribbon Program. The Yellow Ribbon program allows universities (public or private) to supplement this VA benefit, by covering 50 percent of the difference between that universities tuition and the highest public in-State tuition rate. The other 50 percent is covered by the VA.

How has the Yellow Ribbon program improved veteran access to degree granting institutions?

Answer. The Yellow Ribbon Program allows veterans to attend and obtain degrees from private institutions of higher learning or to attend and obtain degrees from out-of-State public institutions of higher learning at no cost or with reduced out-of-pocket expenses at participating schools. There are 1,862 schools, representing 3,269 locations, participating in the Yellow Ribbon Program for the 2013–2014 academic year.

Question. Since implementation, how many veterans, on average, participate in the Yellow Ribbon Program annually?

Answer. VA has not yet collected the data that would allow us to determine the average number of Yellow Ribbon participants. Opportunities to participate in the Yellow Ribbon Program were offered at 1,181 schools in 2009–2010; 1,109 schools in 2010–2011; 2,323 schools in 2011–2012; and 1,859 schools in 2012–2013.

Question. How long does the VA propose to fund this program?

Answer. The Yellow Ribbon Program is a permanent part of the Post-9/11 GI Bill, and as such, is a mandatory expense which is funded through the "Readjustment Benefits" account.

QUESTIONS SUBMITTED BY SENATOR TOM UDALL

Question. As you know I worked to help pass the bipartisan burn pits registry act last year. I believe that the VA should do more to inform veterans about the possible threats to their health from exposure to open burn pits in Iraq and Afghanistan.

What plans does VA have to inform veterans about the possible threats to their health and how will this budget support those efforts?

Answer. VA is committed to the implementation of the burn pit registry and to a strong communications effort with veterans. VA has many ongoing programs to inform veterans of the potential health effects of military service. VA provides a summary of the current scientific assessment of the long-term health consequences

of potential exposure to open burn pits and other airborne hazards on its public health Web site <www.publichealth.va.gov/exposures/burnpits>. In addition to this robust Web site, VA subject matter experts (SMEs) present at various scientific conferences where veterans groups have been in attendance. SMEs also brief Veterans Service Organizations periodically, provide information through VA social media such as Facebook and Twitter, and provide exposure information to veterans subscribed to the GovDelivery listserv. VA intends to leverage these programs within its existing budget and is developing a comprehensive communications plan focused on the burn pits registry. VA has recognized the need for health risk communication and outreach and has included this as an element of its joint VA–DOD Airborne Hazards Action Plan developed in collaboration with DOD. Existing products include a Web site focused on military exposures developed with veteran feedback, a Federal Register notice summarizing VA's response to the October 2011 Institute of Medicine study on the Long Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan, periodic briefings to Veterans Service Organizations (VSO), and educational products to assist VA staff in communicating health risk from potential exposure to burn pits and other airborne hazards to veterans.

Planned communications will continue to emphasize that open burn pit emissions during deployment to Iraq and Afghanistan are one of the many exposures of which veterans need to be aware. VA is conducting epidemiologic studies on health effects associated with deployment to include potential exposure to burn pits and working to establish the Airborne Hazards and Open Burn Pit Registry by January 10, 2014, as required by law. VA's communications plan for the registry has four main objectives:

—Increase awareness of VA's burn pit registry;
—Increase participation in the burn pit registry;
—Increase care of symptomatic veterans and consultations with concerned veterans as appropriate; and
—Foster understanding of VA's commitment and efforts to characterize health effects.

Our primary target for our communication is veterans who served in Iraq, Afghanistan, or the 1990–1991 gulf war. Other audiences will be targeted to enable and encourage them to increase participation in the registry. These audiences include VSOs and other advocacy groups, as well as VA staff, including environmental health coordinators, Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Program managers and advocates, women's health coordinators, vet center counselors, Transition Assistance Program coordinators, and public affairs officers.

Question. Last year the VA and the Indian Health Service announced an agreement in which VA would reimburse IHS for direct healthcare services provided to American Indian and Alaska Native veterans.

What is the status of this partnership, and does the budget provide enough funds to continue expansion of this program to improve access to Native veterans?

Answer. The partnership between VA and Indian Health Service (IHS) continues to grow. For IHS, VA has one signed VA–IHS National Reimbursement Agreement, with 10 signed Local Implementation Plans for Phase 1. This was completed ahead of the VA–IHS Reimbursement Agreement 6-month timeline. VA and IHS are coordinating Phase 2 implementation of all remaining IHS sites. With regard to Tribal Health Program (THP) reimbursements, VA continues to work closely with individual THPs to finalize more VA–THP Reimbursement Agreements. There are currently 29 signed THP Reimbursement Agreements.

Adequate funding is available in the fiscal year 2013 and fiscal year 2014 budgets to continue implementation of the VA–IHS National Reimbursement Agreement and THP agreements.

Question. Like my fellow Senators, the VA Claims backlog is an issue that I am also concerned about and I am committed to working with the VA to reduce these claims and support the shift to a paperless and more efficient system. The current claims process is unacceptable and our veterans deserve better. That being said, I'd like to shift to one of the related challenges of your solution to the backlog—a shift to a paperless system—which creates a significant cybersecurity challenge.

What precautions is the VA taking to protect veterans information in personal records from intrusion, and has the VA worked with other agencies working to reduce the cyber threat such as the military and the national labs through NNSA?

Answer. VA is committed to protecting the information we hold on millions of veterans, their beneficiaries and more than 300,000 VA employees, and protecting the data VA holds on our Nation's veterans is one of our highest priorities. VA is responsible for providing the tools, services and systems that are necessary to protect veteran information at 151 hospitals, 827 community-based outpatient clinics, 57

benefits processing offices, and over 160 cemeteries or memorial sites. Our network supports over 400,000 users, and 750,000 individual devices.

IT security threats continue to evolve. To that end, we have implemented the continuous monitoring program, which constantly checks IT systems and monitors the devices attached to the VA's network.

VA launched the Continuous Readiness in Information Security Program (CRISP) in 2012 to proactively address process and policy deficiencies as well as architecture and configuration issues, and to change the culture of VA's workforce to ensure that veteran information security is "baked into" their daily routine. As part of the CRISP effort, VA conducts rigorous vulnerability scanning, continuous monitoring and patching and software inventory, implementing port security, anti-virus services, and encryption of non-medical IT desktops and laptops. The Department has worked to train staff on the importance of protecting veteran data; as of June 1, over 98 percent of VA's employees have taken mandatory information security training.

In addition, through Web Application Security Assessments, VA is able to identify critical vulnerabilities and potential exploits in VA systems. VA protects the network infrastructure by identifying all networks assets, critical database stores, all external connections, as well as providing the Trusted Internet Connection Gateways services.

VA works with the Department of Homeland Security and other Federal entities to protect VA systems and data.

Question. Last Congress I introduced the Southern New Mexico and El Paso, Texas Veterans Traumatic Brain Injury Care Improvement Act with the hope of bringing attention to the need to create a center where veterans in the region can receive treatment at a polytrauma center or network site. The polytrauma system of care of the Department includes four polytrauma rehabilitation centers and 21 polytrauma network sites, none of which are located within 300 miles driving distance of Fort Bliss, White Sands Missile Range, or Holloman Air Force Base, all areas where many veterans have chosen to reside.

What is VA doing to address the lack of a polytrauma center in the region and will the VA consider locating a center in the area in the future and providing sufficient funding for a polytrauma center?

Answer. VA agrees with the proposal to enhance services for polytrauma and traumatic brain injury (TBI) in the Southern New Mexico and El Paso region by establishing a Polytrauma Support Clinic Team at the El Paso VA Health Care System. This Polytrauma Support Clinic Team, with an enhanced telehealth component at the El Paso VA Health Care System, would meet the needs and the workload volume of veterans with mild to moderate TBI residing in the catchment area and concurrently facilitate access to TBI rehabilitation care for other veterans from rural Texas, Arizona, and New Mexico, through telehealth. In fiscal year 2012, 549 veterans received rehabilitation care related to TBI or polytrauma at the El Paso VA Health Care System. This workload is comparable to that of other Polytrauma Support Clinic Teams and indicates the need for the development of similar capacity at El Paso.

The VA Polytrauma/TBI System of Care consists of four levels of facilities, including: 5 Polytrauma Rehabilitation Centers (PRC), 23 Polytrauma Network Sites (PNS), 87 Polytrauma Support Clinic Teams, and 41 Polytrauma Points of Contact. This integrated, tiered system of specialized care offers comprehensive clinical rehabilitative services including: treatment by interdisciplinary teams of rehabilitation specialists; specialty care management; patient and family education and training; psychosocial support; and advanced rehabilitation and prosthetic technologies.

Veterans recovering from TBI and polytrauma in southern New Mexico and El Paso, Texas, are currently served by the PRC in San Antonio, Texas; the PNS in Tucson, Arizona, Dallas, Texas, and San Antonio, Texas; the Polytrauma Support Clinic Teams in Albuquerque, New Mexico, and Phoenix, Arizona; and the Polytrauma Points of Contact in Amarillo, Texas; Big Spring, Texas; Prescott, Arizona; and El Paso, Texas. These facilities participate in regular educational and training activities focusing on TBI and polytrauma care. Telehealth technologies are used successfully to complement face-to-face clinical encounters and to facilitate access to care for veterans residing at a distance from medical facilities. Services provided via telehealth include rehabilitation assessment and treatment, mental health, and other clinical services.

Question. My office has heard concerns and requested help for many veteran-owned business attempting to work through the Center for Veterans Enterprise verification process. I understand the need to ensure that a business which is claiming veteran-owned status is actually veteran-owned. Businesses that are not veteran-owned should not be receiving the benefits intended for veterans. However, I

am concerned about the pace of the process, especially since some businesses in New Mexico have reported having to wait up to a year or longer for their certification.

Does the VA need more resources to help process these claims and what are your proposals to help veteran-owned businesses, such as those in New Mexico get through the process faster?

Answer. The Center for Veterans Enterprise (CVE) has received the resources needed through the VA Supply Fund to process verification applications. A solicitation for the development of a new case management system, called the Veterans Enterprise Management System (VEMS), is expected to be released in May 2013, with initial capabilities expected in October 2013. This new system will automate many labor-intensive parts of the process, producing increased consistency and efficiency of the program.

By regulation, 38 CFR part 74, CVE has 60 days, when practicable, to process a new verification application once it has been deemed complete. CVE is currently processing new applications in fewer than 40 days. This is down from 73 days at the end of October 2012. VA attributes this to a number of reasons. First, the Verification Assistance Program was created. This program has four parts, where a veteran can take advantage of one or all of the parts. The four parts include: (1) Verification Assistance Briefs that explain common issues that lead to denial in layman's terms; (2) the Verification Self-Assessment Tool that walks the veteran through the regulation and their documentation to determine if the documentation is in compliance with the criteria contained in the regulation; (3) Verification Assistance Partners that offer CVE-trained counselors to assist veterans with their applications; and (4) the Pre-Application Workshop that helps veterans understand what must be included in the application and what to expect from the process. The second factor, introduced in March 2013, is the elimination of certain transfer restrictions, including the right of first refusal, as a basis for denial. The third factor is the new Pre-Determination Findings (PDF) program that was launched May 1, 2013. The PDF program issues a findings letter to every business that would have initially been denied on the basis of the documentation submitted. Those businesses, whose compliance issues are confined to a list of certain easily corrected issues, are allowed to clarify their issues and/or make adjustments to their documentation within a specified time period with the intent to avoid denial. Those businesses with more complicated compliance issues, or who do not wish to make the changes required for compliance are given the opportunity to withdraw their application prior to receiving a denial letter. By withdrawing, they can take the time they need to address the issues and resubmit the application at any time, rather than having to wait in the queue for a request for reconsideration or the 6-month wait period required by regulation before submitting a new application once denied.

Although it is too early to have significant data on the elimination of transfer restrictions and the pre-determination findings, the combined factors have driven the approval percentage on initial applications from 58 percent at the end of fiscal year 2012 to 84 percent at the end of April 2013.

VA believes that those veterans reporting having to wait up to a year or longer for their verification are businesses whose documentation submitted with their initial application was not compliant with the eligibility criteria in the regulation and were subsequently denied. The queue for the request for reconsideration, a process where a firm that was found ineligible can address the issues found and submit the updated documentation, was taking an average of 146 days to process at the end of December 2012. The average processing time for requests for reconsideration fell to 92 days in April 2013. The higher approval percentage of initial applications has driven down the number of businesses entering the request for reconsideration queue, thus reducing the overall queuing time for these businesses. VA expects this trend to continue going forward.

QUESTIONS SUBMITTED BY SENATOR MARK BEGICH

TRIBAL VETERAN REPRESENTATIVES

Question. I am glad to see you have identified rural veterans—$250 million is included for rural health initiatives such as mobile clinics, fee-basis care, and telemedicine. Of particular interest, this funding will also support "exploring collaborations with other Federal and community providers.

You know I have been supportive of expanding services to veterans to community providers, and my push for a Hero Card, has resulted in the successful VA/tribal agreements, I would like to know what "exploring collaborations" with community and Federal providers encompasses?

Answer. VA is committed to increasing access to care closer to home for rural veterans. This includes collaborating with other Federal agencies and community providers to provide care and maintain high-quality standards. For example, under the auspices of the 2010 Memorandum of Understanding (MOU) between VA and IHS, VA increased the number of online clinical trainings available to IHS providers who treat veterans by more than 200 new courses. Another VA–IHS collaborative team established a Bar Code Medication Administration pilot and related training plan for IHS inpatient facilities. Sharing agreements have been established or are being developed between VA and IHS to cover the collaborative use of space, providers, and telehealth equipment.

VA and the Department of Health and Human Services (HHS) recently signed a new MOU that will promote the secure exchange of health information between VA and community healthcare providers and increase the knowledge and expertise of the Health Information Technology (IT) Workforce. This MOU supports the mutual goals of both agencies to have a highly educated health IT workforce that can support the meaningful use of electronic health record technology in rural communities. The MOU also ensures the interoperability and compatibility of VA and community health IT systems that will ensure better coordination of care for rural veterans who are dual users of both VA and non-VA healthcare systems. These non-VA systems may include providers in private practice, at federally qualified healthcare centers, critical access hospitals, and other rural healthcare facilities. Projects created as a result of this MOU include joint VHA Office of Rural Health (ORH) and HHS Office of the National Coordinator for Health Information Technology (ONCHIT) innovative new patient-centered Health Information Exchange pilots that will empower veteran patients to electronically forward information from their VHA Electronic Health Records (EHRs) to non-VA community providers. The goals of this multi-State project are to enhance care coordination, improve medication reconciliation, decrease duplicative lab testing, and increase patient safety. VHA and the Health Resources and Services Administration (HRSA) of HHS are also collaborating and participating in existing rural health provider training initiatives at pilot sites across the country.

Also under the auspices of the VA/HHS MOU, VA is collaborating with the HHS-funded Northeast Telehealth Resource Center to develop a telehealth training curriculum for Certified Nursing Assistants (CNA). The CNA Telemedicine Curriculum will be offered to graduates of the CNA course currently conducted by the Augusta Maine Adult Education program in collaboration with the Togus Maine VA Medical Center. Many rural veterans served by VA supplement their VA care with non-VA healthcare services in their communities. CNAs are widely used in community home healthcare and nursing home settings where utilization of telehealth technologies, especially in rural areas, is projected to grow.

Question. My question is in regard to the Tribal Veteran Representatives (TVRs), this volunteer program trains workers in settings like our tribal health facilities to reach out and sign up veterans in rural areas in VA. I know you have had trainings in Alaska. These individuals serve as points of contact for veterans in their community and as liaisons between the veteran and the VA. They learn about VA healthcare benefits, VA disability, pension, and vocational rehabilitation benefits, and burial and memorial affairs benefits.

Can you tell me what the budget is for these important trainings, I hear there are some funding issues with our Tribal Veteran Representative (TVR) classes that are held in Alaska? The impact of canceling one class is huge and could cost us the momentum we have gained to date. We currently have 109 trained TVRs and one day our dream is to have TVRs in every community. One other item of note is they help us reach people in the communities while on outreach that no one else could. The return on investment is the huge increase in claims and medical coverage in the State. What do you need from us to keep these trainings viable?

Answer. Outreach to American Indian and Native Alaskan veterans to inform them of the benefits and services they may be entitled to is a priority for VA. While there is no established budget for TVR trainings, adequate funding is available to implement this program. VA, like all Federal agencies, is working to increase its efficiency and accountability within programs requiring travel and training, including the TVR program. In addition, VHA is exploring ways to provide this training via video conferencing and other virtual modalities. The most recent TVR training, completed this month in Farwell, Michigan, cost approximately $100,000 for 60 attendees.

VETERANS RETRAINING ASSISTANCE PROGRAM

Question. The increase in FTEs is due to the need for more claims processors as a result of VRAP (Veterans Retraining Assistance Program, be a 35–60 years old veteran, unemployed, 12-month training program in degree or certificate accredited program).

VRAP has had a rough start in Alaska, and thank you for helping with the University of Alaska eligibility, what do you need from us to expand the dates, since some of the rural schools had a late start? Can you give me some numbers on participants in the program and successes?

Answer. There are currently two bills pending in Congress that would extend the end date of the Veterans Retraining Assistance Program (VRAP). S. 6, Putting Our Veterans Back to Work Act of 2013, proposes to extend VRAP through March 31, 2016, as well as add an additional 100,000 slots for veterans to begin training after March 31, 2014. H.R. 562 proposes to extend VRAP for 3 months, making the end date of the program June 30, 2014, instead of March 31, 2014. As of July 19, 2013, 57,409 veterans have used VRAP since the program began in July 2012.

Of the 240 veterans who have been approved for VRAP in the State of Alaska, 64 veterans have been awarded benefits.

SECURITY

Question. My question is about VA police and security. We have received reports of CBOCs and regional offices that have no police coverage or have only contracted security guards. You have been responsive after inquiries from my office in placing a security guard in the Kenai and Wasilla offices. While the main clinic in Anchorage has VA police officers, they are so under staffed that none of the clinics or leased properties have VA police officers. Due to a suicide in the parking lot of our Mat-Su CBOC, we have a contracted, un-armed security guard who leaves the property prior to staff on many occasions, and the Kenai clinic with contracted security, both I understand are not trained in working with veterans, I suggest they take mental health first aid training.

VA/Alaska also leases space at the Northway Mall in Anchorage. They have at least 30 employees working there to include all of C&P staff. It seems as though pocket areas across the country, specifically rural, have less VA police on staff. Perhaps lower staffing numbers may be correlated to an assessment by facilities in communities of low risk; and on the other hand strengthening presence in high crime communities.

I am very concerned about the recruitment/retention. Even before the downgrades started 3 years ago, VA police are underpaid compared to DOD police. What are your plans to beef up security and pay the VA police wages that will retain them?

Answer. In response to growing concern for the safety of our patients and staff at the VA Alaska Healthcare System's four CBOCs, the following measures were incorporated:

—May/June 2012—cameras were brought online which are monitored by VA police during business hours for our most at-risk facilities: Mat-Su and Kenai.

—May 2012—contract security was brought on board for the Mat-Su and Kenai CBOCs.

—VA police physically report to any CBOC for a law enforcement presence when requested or needed.

The CBOCs located in Fairbanks and Juneau have excellent local support and are located in fairly secure areas. Fairbanks is located within the Fort Wainwright military base and perimeter providing on site security and a very speedy response to requests for service. The Juneau CBOC is located within a Federal building inside a perimeter that is protected by a metal detector, 100-percent ID check, and full-time on-site security staff contracted by Federal Protective Service.

Since the incorporation of contract security at Mat-Su and Kenai, there have been no documented reports of concerns or incidents.

In regards to training, a training sergeant provides veteran-specific training to each contract security officer that comes on board. This includes, at minimum:

—security general orientation;

—completion of VA security law enforcement forms and report;

—handling disturbances;

—package examination procedures;

—VA police standard operating procedures;

—response to bomb threats and other disturbances; and

—VA general orientation.

All contract security officers also attend new employee orientation.

Security officers arrive at 0800, when the clinics open, and leave at approximately 1600, which is when the clinics close. Although some staff remain on-site after hours, the clinics are secured at the time of closing.

Question.

$300 Million for Supportive Services for Veteran Families.—The Supportive Services for Veterans Families (SSVF) is one of the first programs the VA has that supports families, and I commend you on your efforts to prevent family homelessness. I know the Catholic Social Services in Alaska has shown some good results in keeping veteran families in their homes, what are your plans for the $300 million in this budget, are you expanding the program?

(HUD–VASH) Case Management; and $250 Million for the Grant and Per Diem Program.—Approximately 75 percent of the increase of the 2013 enacted level is to fund case management for additional HUD–VASH vouchers that VA anticipates will be allocated in fiscal year 2014. HUD–VASH and grant per diem both important to your goal of ending veterans homelessness. I do have concerns about the case management piece. I want you to tell me about VA effort to expand the case management to the community, I don't see why you have to hire VA employees, when there are qualified case managers in the communities, for example, in rural areas, there may not be a CBOC, so chances are the veterans would not be able to access HUD–VASH vouchers. Tell me your plans to look at community case managers (outside of the VA employees).

Answer. The HUD–VASH Program remains a crucial component of VA's Plan to End Homelessness Among Veterans. The HUD–VASH Program is focused on ensuring the most in-need and vulnerable veterans are accessing the valuable resources of the program. To this end, VA closely monitors case loads to ensure they include primarily those who are chronically homeless and in need of intensive case management to navigate the system and sustain long-term housing stability. Partnerships with community agencies are a key strategy in advancing this goal. In addition to actively partnering with communities to outreach and identify chronically homeless veterans, VA recognizes the potential for community agencies to provide contracted case management services in lieu of VA. VA has encouraged medical centers to consider this approach in the past 2 years. To assist VAMCs in their contracting efforts, VA Central Office recently convened an Integrated Product Team (IPT) with the charge of reviewing VA's contracting efforts in the HUD–VASH Program and to determine how best to facilitate contracting as an option for providing case management services. This IPT produced standardized contracting solicitations as well as a new national Statement of Work for VAMC use in pursuing contracting in the future. The IPT standardized products should facilitate a quicker and more efficient contracting process for those VAMCs that choose to contract for case management services.

Unfortunately, many VAMCs attempting to contract for case management services have experienced challenges identifying community agencies with sufficient capacity, experience, and training that can provide the requisite case management services in a cost-effective manner. In fact, VAMCs in both Washington and Alaska attempted to contract for case management services in fiscal year 2012 and ultimately determined contracting would be cost prohibitive. In contracting for case management services, VA must also ensure compliance with all regulatory contracting requirements, a process that can be time intensive. Additionally, some communities have found it difficult to identify agencies willing or able to provide equivalent case management to the standard provided within VA programs. Despite these challenges, VA continues to evaluate and encourage the development of capacity for community case management and is open to suggestions and mechanisms that would allow further engagement with community partners.

LEASES

Question. Can you tell me about the challenge the CBO has created by changing the scoring on medical leases? What impact could this have on veterans if it is not resolved?

Answer. [A response was not provided at press time.]

QUESTIONS SUBMITTED BY SENATOR MARK KIRK

INTEGRATED ELECTRONIC HEALTH RECORD (IEHR)

Question. The VA agreed in March 2011, along with the Department of Defense, to develop an integrated Electronic Health Record (iEHR) for use by both Departments. Earlier this year, the project took a very different turn the decision was

made not to create a truly joint record, but instead develop an "interoperable" record.

VistA must be modernized in order to meet the demands of the iEHR. How much will it cost to modernize VistA, and what is the timeline for modernization? Does the VA have enough information on the end-product to begin work modernizing VistA?

Answer. VistA represents a longstanding and overwhelmingly successful investment on the part of VA that remains viable with a strategic modernization investment. VA is managing VistA modernization via an "open source" strategy. This will allow VA to meet its commitment to keeping the code open source and more rapidly develop and deploy enhanced versions. Our open source model ensures that veteran and clinician needs are met without a slow feedback loop between establishing requirements and development. The availability of VistA as an open source solution provides opportunities for both small and large businesses to offer implementation support as well as value-added enhancements and modernization. In fact, there is already a large VistA developer community that participates in new code development.

VA is managing its open source modernization of VistA through the Open Source Electronic Health Record Agent (OSEHRA), which was established in August 2011 as an essential element of VA's health record modernization initiative. OSEHRA, which we sometimes refer to as a custodial agent, is a code repository with community-structured design, implementation, access, and licensure mechanisms. With over 2,200 members representing 100 companies, OSEHRA already provides a transparent and cost-effective means to incorporate new features and capabilities into the VistA source code.

VistA was made to be adaptable and extendable. Although VistA has been around for some time, the functionality and technology continue to evolve. Major releases and enhancements in the last few years include Bed Management System, Pharmacy Reengineering Emergency Department Information Software, Surgery Quality Workflow Manager, and others. Continuous improvements include over 2,211 changes deployed in incremental patches over the last 3 years. The fact that VA was able to deploy the changes mentioned above emphasizes the ease of change and version control to VistA.

Question. Can it be assured a modernized VistA will be compatible with the new core system the DOD will select so the result is an actual interoperable health record?

Answer. At the joint meeting in early 2013, both Secretary Panetta and Secretary Shinseki codified that both Departments' "cores" must conform to previously agreed upon standards (data, interfaces, enterprise service bus, and user interface) to ensure interoperability. The Secretaries agreed that the DOD core will be seamlessly interoperable.

Question. Has the VA given any consideration to utilizing another core option, like a current commercial off the shelf system or the development of an entirely new system (much like DOD is currently doing)? Why is the VA satisfied with utilizing VistA? Is there a need to review other options?

Answer. Please see the attached "Why VistA?" white paper.

[The referenced white paper was not available at press time.]

Question. How will the end-user (the veterans, the doctors) be affected by the VA and DOD decision to utilize different core systems rather than one joint system?

Answer. If all of the agreed to standards and secretarial commitments are met, the end-user should not be negatively impacted.

Question. Would it be overall less expensive for the two Departments to utilize the same core system (e.g., both use VistA or both use the core DOD selects)?

Answer. It is possible that if both Departments bought and deployed the same core, economies of scale would be achieved and the cost would be less.

Question. The President's fiscal year 2014 request asks for $252 million in development funding for the Interagency Program Office (IPO). That is more than half of the entire IT development request. What will the IPO produce in fiscal year 2014 with this development funding? Outline specific expected deliverables in fiscal year 2014.

Answer. The President's fiscal year 2014 request for iEHR includes funds that will be obligated by both VA and IPO to deliver key functionality of the iEHR program. This includes the modernization of VistA and delivery of key products needed in order to make the 2014 IOC delivery date. The funds include money for the Virtual Lifetime Electronic Record-Health, patient scheduling, systems integration, pharmacy, laboratory, order services, and development of the enterprise service bus, among other key deliverables.

Question. How will the iEHR Initial Operating Capability (IOC) "play a critical role in resolving the major pharmacy challenges that are currently being experienced at the James A. Lovell Federal Health Care Center?" (Page 5A–47 volume 2.)

Answer. IOC will not play a critical role in resolving the pharmacy challenges. IOC is about delivering on the commitment to deploying a single, joint, common, iEHR system that is based on an open architecture and non-proprietary in design. In addition, VA is committed to fixing the pharmacy issue at the James A. Lovell Federal Health Care Center in North Chicago through the Data Management Service and other initiatives specific to North Chicago.

CLAIMS PROCESSING

Question. Mr. Secretary, the VA has received a lot of press lately—none of it complementary—regarding an issue that we have long followed here on this subcommittee, claims processing. In spite of Congress's appropriation of additional funds to address personnel and technological issues, the backlog continues to grow and has now reached unbelievable levels, especially in Chicago.

When will we know if your efforts to reduce the backlog are working?

Answer. Right now, too many veterans wait too long to receive benefits they deserve. This has never been acceptable to the Department of Veterans Affairs (VA) or to the dedicated employees of VBA—52 percent of who are veterans themselves. VBA is aggressively implementing its Transformation Plan, a series of people, process, and technology initiatives designed to eliminate the claims backlog and achieve our goal of processing all claims within 125 days with 98-percent accuracy in 2015. VBA is retraining, reorganizing, streamlining business processes, and building and implementing technology solutions based on the newly redesigned processes in order to improve benefits delivery.

Initially planned for deployment throughout fiscal year 2013, VBA accelerated the implementation of the new organizational model by 9 months, beginning in fiscal year 2012, due to early indications of its positive impact on performance. Given the magnitude of this change, each office transitioned to the new organizational model individually. Significant support and training were critical throughout this transition. As of March 2013, the new organizational model was fully operational at all 56 regional offices. As is anticipated with any change of this magnitude, there was some short-term impact on performance as we ensured that the training, communications, and other essential change management activities were conducted to appropriately prepare the workforce.

At the same time we also began the nationwide deployment of our new paperless electronic claims processing system, the Veterans Benefits Management System (VBMS). Generation One of VBMS began in 2010 with the conceptualization, piloting, development, and deployment of baseline system functionality with improved quality (required actions and automation) and efficiency (no paper). VBA began deployment of VBMS Generation One in September 2012, concluding the calendar year with 18 stations on the system. It is important to note that early adopters of first generation technology participated heavily in the development and refinement of efficiencies and functionality of the system, which had a direct impact on productivity as a result of the live test environment. These stations paved the way for the accelerated deployment of VBMS, which will enable VBA to track and measure productivity outcomes in a consistent and accurate manner once all regional offices are operating with the new technology and after a period of stabilization. The first 18 stations enabled VBA to also test business processes and functionality for the establishment of eFolders in VBMS and the model for tracking and shipping of paper-based claims with two scanning vendors. Generation One of VBMS concluded with the successful implementation of Release 4.1 in January 2013. This generation culminated in a foundational Web-based, electronic claims processing solution. Under our accelerated deployment schedule, all 56 regional offices and our Appeals Management Center are now using VBMS. Each VBMS site deployment is also supported by organizational change management practices (including extensive training) to ensure employees are able to adapt to and adopt the new technologies and solutions. We will also continue to enhance the automated functionalities and build additional system capabilities in three future generations of VBMS to be deployed over the next 2 years. As we move into future generations of VBMS, our focus is on leveraging more complex automation features and more extensive data exchange and system integration capabilities so that our employees will be able to process claims electronically from receipt to payment.

VBA is tracking execution of its transformation initiatives against our key measures of performance, including pending and completed ratings, timeliness, accuracy, and the impact on the backlog. The quality of the transformation initiatives is meas-

ured through a 3-month rolling average accuracy metric that is reported on VA's ASPIRE Web site which can be found at http://www.vba.va.gov/reports/aspiremap.asp. VA projected that the backlog (claims pending over 125 days) would be approximately 595,000 claims at the end of fiscal year 2013. We are currently significantly below that projection. As of May 14, 2013, there are 566,802 claims in the backlog (67.3 percent of the inventory). This is down from a peak of 611,073 claims on March 25, 2013—a reduction of 44,271 backlogged claims in less than 2 months.

Question. When will we begin seeing a turnaround at regional offices like Chicago?

Answer. On April 19, 2013, VA announced a new initiative to expedite compensation claims decisions for veterans who have waited 1 year or longer. Under this initiative, VA expects to have all claims pending over 1 year eliminated from the current claims backlog within 6 months. As of June 15, 2013, over 2,700 Illinois veterans received a decision on their pending claims. On June 20, 2013, VBA shifted its focus to claims that have been pending over 1 year. Many veterans served at the Chicago Regional Office (RO) will be provided decisions on their claims as a result of this initiative. VA claims raters are making provisional decisions on the oldest claims in inventory, which will allow veterans to begin collecting compensation benefits more quickly, if eligible. Veterans will be able to submit additional evidence for consideration a full year after the provisional rating, before the VA issues a final decision. Provisional decisions will be based on all evidence provided to date by the veteran or obtained on their behalf by VA. If a VA medical examination is needed to decide the claim, it will be ordered and expedited.

It is important to understand that as a result of this initiative, metrics used to track benefits claims will experience significant fluctuations. The focus on processing the oldest claims will cause the overall measure of the average length of time to complete a claim—currently 314 days nationally—to skew, rising significantly in the near term because of the number of old claims that will be completed. Over time, as the backlog of oldest claims is cleared and more of the incoming claims are processed electronically through VA's new paperless processing system, VA's average time to complete claims will significantly improve. In addition, the average days pending metric—or the average age of a claim in the inventory—will decrease, since the oldest claims will no longer be part of the inventory.

Question. By the end of 2013, what type of backlog should we expect to see at regional offices around the country?

Answer. VA projected that the backlog (claims pending over 125 days) would be approximately 595,000 claims at the end of fiscal year 2013. We are currently significantly below that projection. As of May 14, 2013, there are 566,802 claims in the backlog (67.3 percent of the inventory). This is down from a peak of 611,073 claims on March 25, 2013—a reduction of 44,271 backlogged claims in less than 2 months.

Question. What constitutes an accurate claim? How is accuracy determined?

Answer. VBA's Quality Assurance Program currently measures accuracy of disability compensation claims on two different levels. The first assessment is based on review of the claim as a whole (claim-level) with all claimed disabilities or issues associated with a work credit known as an end product (EP). Audit-style case reviews are conducted after completion of all required processing actions on a claim. The review represents a measure of accuracy of all adjudicative actions to include addressing all issues, completing all required evidence gathering actions, appropriately granting or denying benefits, assigning correct evaluations and effective dates, and paying the correct amount of benefits. Accuracy of the claim is determined if all of these adjudicative actions are processed correctly. If there is deficiency in any of these elements that would ultimately impact the outcome of the decision, the entire claim or EP is considered inaccurate. This process is considered an "outcome-based" accuracy review.

In addition to the claim-level accuracy measurement, VBA began recording the accuracy of decisions at the issue-level on October 1, 2012. The premise of the issue-level review is generally the same; however, each claimed disability or issue is independently determined as correct or incorrect regardless of its impact on the other decisions. This measurement of accuracy provides a more detailed and accurate assessment of the work completed by field stations. The data collected at this level allows for more focused training and will drive behaviors that will ultimately improve the quality of decisions.

Question. When will electronic claims filing be available to all veterans?

Answer. Currently, all veterans are able to file certain claims electronically. Veterans can file electronic claims for disability compensation including fully developed claims, additions and changes to dependents, and claims for approval of school attendance. Veterans can also request the appointment of a Veterans Service Organi-

zation (VSO) as the claimant's representative and authorize and consent to release information to VA electronically.

Additional electronic claims capabilities expected to be available to all veterans and VSOs later in 2013 will include:

—Applications for increased compensation based on unemployability;

—Statements in support of claim for service connection for Post-traumatic Stress Disorder (PTSD) and PTSD secondary to personal assault; and

—Applications for burial benefits.

Through its Veterans Relationship Management initiative, VA has made it easy to file claims electronically by providing two entry portals:

—eBenefits is available for veterans who want to file a claim on their own. This is a joint VA/Department of Defense (DOD) Web portal that provides resources and self-service capabilities to veterans, servicemembers, and their families to research, access, and manage their VA benefits, military benefits, and personal information. eBenefits allows veterans, using a free premium account, to submit claims and upload supporting documentation.

—The Stakeholder Enterprise Portal (SEP) will expand access to our external business partners, such as VSOs, education providers, physicians, attorneys, loan appraisers, other benefits providers who will be able to electronically access information, submit claims, and perform other actions on behalf of veterans. SEP currently allows members of accredited VSOs to electronically complete the same types of claims that are available for veterans to submit, upload supporting documents, view the status of claims, view payment history and details, and accept or reject power of attorney applications.

Our veterans deserve a timely and positive experience each time they contact VA. We are committed to making dramatic improvements, and will continue our aggressive efforts to ensure we are providing accurate and comprehensive information and assistance to our veterans and their families in a professional and compassionate manner.

Question. How many veterans currently receive VA benefits after going through the Integrated Disability Evaluation System (IDES)? If such figures were included in the total number of pending and completed claims, how would it affect the backlog figures?

Answer. In fiscal year 2012, 14,192 veterans completed VA benefit claims through IDES. In fiscal year 2013 (as of May 13, 2013), 12,737 veterans have completed VA claims through IDES. All completed IDES claims are counted in VA's total number of completed claims. Once VA is notified that an IDES participant has been medically separated from the military, the IDES claim becomes part of VA's pending disability claims workload. It would not be appropriate to consider IDES claims from servicemembers whose fitness for continued service has not yet been adjudicated by the military as part of VA's pending workload.

Question. It has recently been noted that a "veteran's claim sits stagnant for up to 175 days as VA awaits transfer of complete STR (service treatment records) from DOD." How can Congress assist the VA in coordinating with the Department of Defense to improve this wait time?

Answer. VBA continues to regularly and diligently work with DOD to obtain complete service treatment records (STR) faster and more efficiently. As such, no congressional action is needed.

One of the largest endeavors VA and DOD are working towards jointly is the electronic transfer of STRs to VA. On December 6, 2012, VBA reached an agreement with DOD requiring the military services to certify a servicemember's STRs as complete as possible at the point of transfer to VA. Effective January 1, 2013, all five military services began full implementation of STR certification.

VA asked for and received two accounts for each VBA regional office into DOD's Armed Forces Health Longitudinal Technology Application (AHLTA) system, which enables VBA to review any DOD records that VBA does not already possess in order to complete claims. The AHLTA print-to-portable document format (PDF) pilot is scheduled to begin in September 2013 to provide VA electronic data (PDF) of information contained in AHLTA.

DOD will also deploy the Healthcare Artifact and Image Management Solution (HAIMS) to provide a mechanism for scanning and uploading paper documents to make them readily available to VA. Additionally, the technology could also be used to scan and upload paper medical record items received from private-sector providers. DOD has initiated an accelerated deployment schedule for HAIMS with a goal of stopping the flow of paper STRs to VA by December 2013.

Further, VBA has an agreement with DOD to provide 100-percent-complete service treatment and personnel records in an integrated Electronic Health Record (iEHR) for the 300,000 Active Duty, National Guard, and Reserve servicemembers

departing annually. This will increase the number of fully developed claims submitted. In the short term HAIMS and in the long term iEHR are both critical efforts to reduce the time for VA to receive STRs from DOD significantly.

MANDATORY FUNDING

Question. Mr. Secretary, you stated in your budget request $86.1 billion is needed to satisfy entitlement spending for VA's mandatory programs in fiscal year 2014. This is an 18-percent increase over the fiscal year 2013 enacted level. The fiscal year 2013 request was also a 17-percent increase over the previous fiscal year 2012 enacted level.

Do you foresee a trend where the VA's mandatory spending will continue to increase each year by upwards of 20 percent? Should we continue to expect such large mandatory increases each year?

Answer. While the budget authority for VA's mandatory programs increased by these amounts, overall mandatory obligations are not increasing upwards of 20 percent. Of the $86.1 billion appropriation requested for VA's mandatory programs in fiscal year 2014, $71.2 billion, or 83 percent, is for the Compensation and Pension (C&P) account and $13.1 billion, or 15 percent, is for the Readjustment Benefits (RB) account. Total obligations for these accounts grew 7.3 percent and 3.8 percent, respectively.

The fiscal year 2014 budget authority for the C&P account increased 16 percent over the fiscal year 2013 level; however, total obligations increased just 7.3 percent over the fiscal year 2013 level. The larger increase in budget authority is due to an unobligated balance of $5.0 billion at the end of fiscal year 2012 which was carried into fiscal year 2013. Funds appropriated to the C&P and RB accounts are authorized to obligate until expended. Therefore, the $5.0 billion unobligated balance at the end of fiscal year 2012 reduced the amount of new budget authority required for fiscal year 2013. The fiscal year 2013 budget authority also reflects a request for a transfer from the RB account to the C&P account to fully fund fiscal year 2013 obligations. This request is consistent with the administrative provision section 201, and when coupled with the $5 billion in previously authorized funding available for obligation in fiscal year 2013 and $60.6 billion appropriation, supports anticipated obligations of $66.4 billion.

In addition, the fiscal year 2014 appropriation request for C&P does not anticipate an unobligated balance carried forward from fiscal year 2013; therefore, budget authority equals obligations in fiscal year 2014. Obligations for the C&P account are expected to continue to increase at historical levels of around 7 percent annually. Please see the following chart for additional detail.

	Compensation and pension funding (dollars in thousands)			Percent Change	
	Fiscal year 2012	Fiscal year 2013	Fiscal year 2014	Fiscal year 2012 to fiscal year 2013	Fiscal year 2013 to fiscal year 2014
Appropriation	$51,237,567	$60,599,855	$71,248,171	18.3%	17.6%
Transfer from RB	.....	824,838	.....	N/A	N/A
Appropriation Adjusted	51,237,567	61,424,693	71,248,171	19.9	16.0
Unobligated Balance SOY	12,930,390	5,000,894	.....	N/A	N/A
Total Funding Available	64,167,957	66,425,587	71,248,171	3.5	7.3
Obligations	59,167,063	66,425,587	71,248,171	12.3	7.3

Similarly for the RB account, while the fiscal year 2014 appropriation request was 17.3 percent over the fiscal year 2013 level, fiscal year 2014 obligations are expected to increase just 3.8 percent over fiscal year 2013 levels. This is primarily due to an unobligated balance of nearly $2.6 billion that was carried into fiscal year 2013 which, in addition to the new budget authority of $11.2 billion and $321.6 million in collections from DOD, is available to fund benefits. Please see the following chart for additional detail.

	Readjustment benefits funding (dollars in thousands)			Percent Change	
	Fiscal year 2012	Fiscal year 2013	Fiscal year 2014	Fiscal year 2012 to fiscal year 2013	Fiscal year 2013 to fiscal year 2014
Appropriation	$12,108,488	$12,023,458	$13,135,898	−0.7%	9.3%
Transfer to C&P	.....	−824,838	.....	N/A	N/A
Appropriation Adjusted	12,108,488	11,198,620	13,135,898	−7.5	17.3
Unobligated Balance SOY	1,221,327	2,554,542	577,047	N/A	N/A
Collections from DOD	365,193	321,581	303,698	−11.9	−5.6
Total Funding Available	13,695,008	14,074,742	14,016,644	2.8	−0.4
Obligations	11,140,466	13,497,695	14,016,644	21.2	3.8

Question. Will you explain the major factors contributing to this large yearly increase in mandatory entitlement spending?

Answer. Please see the response to question 1. In addition, while the budget authority for VA's mandatory programs increased by these amounts, overall mandatory obligations are not increasing upwards of 20 percent. Obligations for the C&P and RB accounts, which make 98 percent of the mandatory request for fiscal year 2014, increase by a combined 6.6 percent, from $79.9 billion in fiscal year 2013 to $85.2 billion in fiscal year 2014. Mandatory obligations are expected to increase consistently with historical annual increases of around 7 percent. Increases in obligations are consistent with net increases in caseload, an upward trend in veterans' average degree of disability, increases in the cost of education, and cost-of-living adjustments to monthly payments.

Question. Is there anything Congress can do to help the VA reduce its mandatory spending?

Answer. Mandatory spending provides entitlement benefit payments to eligible veterans, their survivors, and dependents. VA is legally obligated to make payments or provide aid to eligible veterans. VA is committed to uphold President Lincoln's promise, "To care for him who shall have borne the battle, and for his widow, and his orphan." VA welcomes discussion to determine best practices to meet the needs of the Nation's veterans and families.

CONSTRUCTION

Question. Mr. Secretary, the fiscal year 2014 budget requests $342 million for major construction. This continues the reduction we have seen over the past few years in the account. Yet, your Department's estimated cost for fully funding all major construction infrastructure is nearly $23 billion.

In light of these funding cuts to major construction and this downward trend, does the Department need to reassess its capital asset program? Is there a plan to reconcile the major construction backlog with future funding needs?

Answer. The fiscal year 2014 budget request and fiscal year 2014 advanced appropriations provide the necessary resources to care for our Nation's veterans. The VA's 2014 budget request would provide resources to allocate funding between a mix of operating and capital accounts, to deliver the best mix of services for veterans. In addition to expanding access to VA services through the construction and renovation of facilities, VA provides access to veterans through non-capital solutions such as: fee care, telehealth, beneficiary travel, veteran transportation services, etc.

In fiscal year 2014, the budget request funds the completion of the mental health building in Seattle, Washington, which is the highest priority partially funded project from the list of outstanding projects that previously received congressionally appropriated funds.

MENTAL HEALTH

Question. Mr. Secretary, last year the VA initiated a hiring process to bring on board 1,900 mental health professionals and support staff. This is supposed to be completed by June 30, 2013.

Will you explain the hiring status to date of these 300 administrative staff and the 1,600 mental health professionals?

Answer. The VA Mental Health Hiring Initiative has improved the Veterans Health Administration's (VHA) ability to expand access to mental health services to our Nation's veterans. As of June 3, 2013, VHA has hired 1,607 clinical staff to fill

the 1,600 new mental health positions in accordance with the President's Executive order issued on August 31, 2012. Additionally, VHA has hired 297 of the 300 new non-clinical positions.

Question. The VA stated it planned to hire 800 peer-to-peer counselors. Will you elaborate on that plan?

Have all 800 counselors been hired to date?

Answer. As of June 4, 2013, 335 peer-to-peer counselors have been hired in support of the goal to hire 800 by December 31, 2013.

What is the role of a peer-to-peer counselor?

Answer. Peer-to-peer counselors perform a variety of therapeutic and supportive tasks including:

—assisting their peers in articulating their goals for recovery;
—helping their peers to learn and practice new skills;
—helping their peers monitor their progress;
—assisting them in their treatment;
—modeling effective coping techniques and self-help strategies based on the counselor's own recovery experience; and
—supporting their peers in advocating for themselves to obtain effective services.

Where will these counselors be located?

Answer. Peer-to-peer counselors will be geographically dispersed across all of the VISNs to ensure veterans have access to the required staffing levels. VA implemented staffing model guidance with the list of skilled procedures and the number of providers that must be available to every 1,000 veterans seeking services for mental health. By the end of fiscal year 2013, there should be at least three counselors at each medical center and at least two counselors at each very large CBOC.

Question. When would a veteran see a peer-to-peer counselor instead of a mental health professional or do the two work in concert with one another on a veteran's particular case?

Answer. Peer-to-peer counselors function as part of an interdisciplinary team. They do not provide services that replace the services provided by degreed mental health professionals. Their work is adjunctive to the work of degreed professionals. peer-to-peer counselors are full members of the treatment team and provide a unique perspective and set of services. By virtue of the fact that peer-to-peer counselors are veterans who have been or are currently in recovery from a mental health condition, they are role models who serve as an example that recovery is attainable. They facilitate peer support groups, assist with the development of treatment plans, provide crisis support, and act as advocates for the veterans. These services work hand-in-hand with the services provided by the other members of the treatment team (e.g., medications, psychotherapy, placement services) to provide a comprehensive, holistic, and recovery-oriented approach to mental health treatment.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

Question. Please provide an updated timeline for the design and construction phases for the new Robley Rex VA Medical Center in Louisville, Kentucky.

Answer. The following timeline is as of May 2013. Projected dates are based on current status and assumptions, and are subject to change:

—Design commenced in March 2013, and VA received the design concept submission in late April 2013 which is being revised by the architect-engineer.
—VA anticipates receipt of a revised concept submission and selection of preferred concept for design in spring 2013. VA anticipates starting Schematic Design at this time with completion by late winter 2014.
—Design development can commence in early 2014 and can complete in the fall of 2014.
—Construction documents can commence the fall of 2014 and can be complete in the summer of 2015.
—The construction schedule is to be determined based on when funding is received.

Question. What specific steps has the VA taken to successfully plan for the large influx of currently Active Duty military personnel that will enter the VA system over the coming years?

Answer. For several years, the Department of Veterans Affairs (VA) has worked with the Department of Defense (DOD) to ensure Active Duty personnel are informed of VA programs and to help them transition to VA benefits and services. As enrollment increased, additional programs have been put in place and existing programs improved.

TRANSITION ASSISTANCE

In August 2011, the President called on DOD and VA to lead a task force with the White House economic and domestic policy teams and other agencies, including the Department of Labor (DOL), to develop proposals to maximize the career readiness of all servicemembers. This DOD–Veterans Employment Initiative Task Force is one element of the plan to reduce veteran unemployment and to ensure that all of America's veterans have the support they need and deserve when they leave the military, look for a job, and enter the civilian workforce.

To meet the President's call for a "career-ready military," the DOD–VA Veterans Employment Initiative Task Force developed a new training and services delivery model to help strengthen the transition of our servicemembers from military to civilian life as they become veterans. This model represents an improved DOD/VA/DOL Transition Assistance Program (TAP), called Transition Goals, Plans, and Success (GPS). The new model was implemented in November 2012 as part of the 2012 VOW to Hire Heroes Act (VOW Act) and includes four parts:

—*Pre-Separation Counseling.*—Servicemembers will conduct individual assessments and one-on-one counseling with military service representatives.

—*Employment Workshop.*—DOL will assist servicemembers with translating military skills, searching for jobs, writing resumes, and interviewing.

—*Enhanced VA Benefit Briefings.*—Veterans, servicemembers, their families, and survivors will attend comprehensive workshops covering the entire spectrum of VA benefits.

—*Individual Transition Plan.*—A customized roadmap to tailor individual needs for success will be completed for every transitioning servicemember. Servicemembers will also have the option of attending one or more of the following 2-day Transition GPS Tracks:

  —*Education Track.*—Servicemembers pursuing college education will receive guidance to prepare for the college application process.

  —*Career Technical Training Track.*—Servicemembers pursuing further technical training will receive guidance and help in selecting schools and technical fields.

  —*Entrepreneurship Track.*—Servicemembers pursuing self-employment in the private or nonprofit sector will learn about the challenges faced by entrepreneurs, the benefits and realities of entrepreneurship, and the steps toward business ownership.

Based upon VA's analysis of projected military service separation data, it has developed models for the optimal delivery and support of the VOW Act and Transition GPS. This support utilizes a regional hub-and-spoke model. VA will deliver enhanced VA benefits briefings within the framework of Transition GPS and is responsible for providing the Transition Technical Training Track. VA will fully participate in the Capstone event, a final review of the transitioning servicemember's completion of the workshops and tracks, and ensure representatives are available to receive and coordinate a "warm handover" for servicemembers requiring additional support from VA regarding benefits, services, and other programs.

HEALTHCARE

VA has taken a number of actions in collaboration with DOD to identify and track servicemembers who are transitioning to civilian life and to ensure that those in need of care are properly identified. VA and DOD transition assets and capabilities include:

—liaison and care coordination staff to facilitate a seamless transition process;

—enhanced health information sharing and numerous interagency initiatives that support shared standards of care; and

—interoperable processes for care delivery that facilitates transition between the systems.

For example, VA has 43 VA liaisons for healthcare stationed at 21 Military Treatment Facilities (MTF). VA liaisons for healthcare, either licensed social workers or registered nurses, are co-located in MTFs, under DOD's Care Management and Social Work Service, Office of Patient Care Services, with concentrations of recovering servicemembers returning from Iraq and Afghanistan. VA liaisons coordinate healthcare as servicemembers transition from MTFs to a VA healthcare facility closest to their homes or most appropriately located for the specialized services their medical condition requires. VA liaisons connect with VA's Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) program manager to coordinate this initial care and to have a VA case manager assigned with the expectation that the servicemember will leave the MTF registered for VA healthcare with a scheduled VA appointment.

VA has also coordinated with DOD's inTransition program to develop and provide joint training for staff to promote referrals from VA and DOD providers to the inTransition program. inTransition is a DOD program to assist servicemembers requiring behavioral health treatment and who are transitioning between healthcare systems, status, or location. inTransition's mission is to support continuity of care for the servicemember during transition.

ADDITIONAL HEALTHCARE EFFORTS

There are several efforts by VA to reach out to departing military personnel, which allows VHA to gauge the number of members turning to VA in order to adjust programs for future demand.

Individual Ready Reserve (IRR) Muster Events.—DOD provides VA with dates and locations of the "live" Musters for the Marines and the Army Reserve. VHA OEF/OIF staff conducts the 20-minute VHA briefing to the attendees and the enrollment procedures. Many of these events are held at VAMCs. Since 2009 the field has recorded that over 42,000 IRR members have attended these VA briefings with over 13,000 enrolling into VA healthcare. Since January 2013, the Marines and Air Force will continue "live" Musters. The Navy and Army are developing "virtual musters". Outreach staff is developing "electronic" VA outreach materials in order to partner with the services in sending out electronic materials to this population.

DOD's Yellow Ribbon Reintegration Program.—This program was established in 2008 and was implemented for all Reserve component servicemembers and their families: VA is a major support partner at VAMCs, regional offices and vet centers for these events and provides "boots on the ground" assistance and offers enrolment and referrals for needed services. Specialized briefings are offered by VA staff on suicide prevention, PTSD, TBI etc. The DOD Post Deployment Health Reassessment (PDHRA) is a healthcare screening, required for all National Guard and Reserve servicemembers 90–180 days post-deployment. As part of the Yellow Ribbon Program at the 60–90 day event, all members are given the opportunity to complete this screening evaluation. The PDHRA results in referrals to VA facilities, such as VA medical centers, VA community clinics, and vet centers. Local VAMC and vet center staff provide outreach, education, enrollment, and as needed, referral for clinical services. Referred veterans have a choice to receive care at a local VAMC, vet center, MTF, or through TRICARE. For servicemembers who request a VHA appointment during on-site PDHRA, VA personnel are able to schedule appointments for them at their local VAMC.

National Guard Partnership.—In order to ensure that OEF/OIF/OND combat veterans receive access to high-quality healthcare and coordinated VA services and benefits, VA and the National Guard (NG) developed a creative partnership. The NG hired 54 (now 64) National Guard Transition Assistance Advisors (TAA) to serve as VA/NG liaisons in the field at the State level to assist NG servicemembers and their families with questions and assistance to access VA benefits and services. VA staff conducted the training to enhance the outreach skills of the TAAs. The TAAs have been the critical link in facilitating access to VA by NG/Reserves returning combat troops in each of the 50 States and 4 territories of Puerto Rico, Virgin Islands, Guam, and the District of Columbia. TAAs have provided outreach to over 275,000 NG members and families. Since 2008, TAAs have facilitated VHA enrollment or referrals for over 130,000 veterans and over 113,000 to VBA and over 55,000 to vet centers.

Question. With an already high unemployment rate, what is the VA doing to help ensure that servicemembers are able to find jobs when they return to civilian life?

Answer. VA is helping to confront the issue of veteran unemployment by first giving our veterans a strong foundation of education and training on which to build their careers. The Post-9/11 GI Bill provides financial support to veterans to pursue undergraduate and professional degrees, vocational and technical training, licenses, and certifications, and training in entrepreneurship.

In addition, the Veterans Retraining Assistance Program (VRAP) helps retrain those veterans hit hardest by unemployment. VRAP is available to unemployed veterans between the ages of 35 and 60. VA has provided over $318.6 million in program benefits to the more than 51,784 veterans enrolled in a training program.

In addition to giving veterans a strong foundation of knowledge and training, VA has long offered employment services through the Vocational Rehabilitation and Employment (VR&E) program. More than 800 Vocational Rehabilitation Counselors (VRC) and over 90 Employment Coordinators (EC) assist veterans with service-connected disabilities prepare for, find, and keep suitable jobs. VRCs help veterans evaluate their interests, aptitudes, and capabilities to determine a career path. ECs

leverage relationships with civilian employers to help match each veteran with an appropriate work place.

Over the last 2 years, VA significantly improved veterans' access to online employment resources. VA's VetSuccess.gov Web site integrates the tools and information veterans need to find employment and advance their careers. The joint VA–DOD eBenefits portal assists transitioning servicemembers and veterans in their job search by including a searchable online personnel file where veterans can access important service records and a "Career Center" with tools to help veterans complete self-assessments, translate their military skills to civilian occupations, and build their resumes.

VA is leading the Federal Government in hiring veterans through our VA For Vets Program. Part of the Veterans Employment Services Office, the VA For Vets Program is fully dedicated to aiding veterans in finding Federal employment and preparing job-seeking veterans for careers at VA. The program assists veterans in translating their military skills and training into civilian careers, and teaches human resource professionals and supervisors how to recruit and retain veterans. In its first year, VA For Vets offered career coaching to 19,000 veterans and helped produce over 28,000 veteran resumes.

VA has partnered with the U.S. Chamber of Commerce to support the Chamber's "Hiring Our Heroes" job fairs. Per a memorandum of understanding between our two organizations, VA participates in Chamber of Commerce job fairs across the country to advertise and educate veterans on VA benefits and services.

VA has also partnered with the First Lady's and Dr. Jill Biden's Joining Forces Initiative dedicated to connecting our servicemembers, veterans and military spouses with the resources they need to find jobs at home.

VBA is also working with partner agencies to collaboratively address veterans employment, including participating in a White House forum on credentialing. The forum seeks to bring together stakeholders from both State and Federal Government, as well as the private sector, to discuss how veterans can more easily obtain licenses and certifications based on their military experience and obtain academic credit for their military duty.

In addition, VHA has developed a pilot program to hire medics and corpsmen as emergency response technicians. This program enables transitioning medics and corpsmen to obtain ready employment in the VA, help meet VA workforce needs, enable them to serve other veterans, and obtain advanced training and licensure (as nurses, physician assistants, etc.) creating a pipeline for needed VA employees.

Question. Numerous Kentucky veterans have expressed their concerns about the massive backlog in claims at the VA—which has increased and now totals over 860,000 pending claims. Why has the VA not reduced this backlog in claims?

Answer. Right now, too many veterans wait too long to receive benefits they deserve. This has never been acceptable to VA or to the dedicated employees of VBA—52 percent of whom are veterans themselves. VBA is implementing its Transformation Plan, a series of people, process, and technology initiatives designed to eliminate the claims backlog and achieve our goal of processing all claims within 125 days with 98-percent accuracy in 2015. VBA is retraining, reorganizing, streamlining business processes, and building and implementing technology solutions based on the newly redesigned processes in order to improve benefits delivery. It is important to note that the VA Strategic Plan to Eliminate the Compensation Claims Backlog sent to Congress in January of 2013 (http://benefits.va.gov/transformation/docs/va__strategic__plan__to__eliminate__the__compensation__claims__backlog.pdf) indicates that the inventory of claims would continue to increase for the near term before declining.

Initially planned for deployment throughout fiscal year 2013, VBA accelerated the implementation of the new organizational model by 9 months, beginning in fiscal year 2012, due to early indications of its positive impact on performance. Given the magnitude of this change, each office transitioned to the new organizational model individually. Significant support and training were critical throughout this transition. As of March 2013, the new organizational model was fully operational at all 56 regional offices. As is anticipated with any change of this magnitude, there was some short-term impact on performance as we ensured that the training, communications, and other essential change management activities were conducted to appropriately prepare the workforce.

At the same time we also began the nationwide deployment of our new paperless electronic claims processing system, the Veterans Benefits Management System (VBMS). Generation One of VBMS began in 2010 with the conceptualization, piloting, development, and deployment of baseline system functionality with improved quality (required actions and automation) and efficiency (no paper). VBA began deployment of VBMS Generation One in September 2012, concluding the calendar

year with 18 stations on the system. It is important to note that early adopters of first generation technology participated heavily in the development and refinement of efficiencies and functionality of the system, which had a direct impact on productivity as a result of the live test environment. These stations paved the way for the accelerated deployment of VBMS, which will enable VBA to track and measure productivity outcomes in a consistent and accurate manner once all regional offices are operating with the new technology and after a period of stabilization. The first 18 stations enabled VBA to also test business processes and functionality for the establishment of eFolders in VBMS and the model for tracking and shipping of paper-based claims with two scanning vendors. Generation One of VBMS concluded with the successful implementation of Release 4.1 in January 2013. This generation culminated in a foundational Web-based, electronic claims processing solution. Under our accelerated deployment schedule, all 56 regional offices and our Appeals Management Center are now using VBMS. Each VBMS site deployment is also supported by organizational change management practices (including extensive training) to ensure employees are able to adapt to and adopt the new technologies and solutions. We will also continue to enhance the automated functionalities and build additional system capabilities in three future generations of VBMS to be deployed over the next 2 years. As we move into future generations of VBMS, our focus is on leveraging more complex automation features and more extensive data exchange and system integration capabilities so that our employees will be able to process claims electronically from receipt to payment.

VBA is tracking execution of its transformation initiatives against our key measures of performance, including pending and completed rating, timeliness, accuracy, and the impact on the backlog. The quality of the transformation initiatives is measured through a 3-month rolling average accuracy metric that is reported on VA's ASPIRE Web site which can be found at http://www.vba.va.gov/reports/aspiremap.asp.

A major factor impacting all areas of VA's disability claims workload was the addition of three new agent orange presumptive disabilities. In 2009, Secretary Shinseki made the decision to add the three presumptive conditions (Parkinson's disease, ischemic heart disease, and B-cell leukemias) for veterans who served in the Republic of Vietnam or were otherwise exposed to the herbicide agent orange. Due to this policy change, the number of compensation and pension claims received increased from 1 million in 2009 to 1.3 million in 2011 (a 30-percent increase). In addition, beginning in October 2010, VBA identified these claims for special handling to ensure compliance with the provisions in the *Nehmer* court decision that requires VA to readjudicate claims for these three conditions that were previously denied. VBA dedicated over 2,300 claims staff to readjudicating these claims. *Nehmer* claims for all live veterans were completed as of April 2012 and *Nehmer* survivor claims were completed in October 2012. The claims staff is now working on reducing the backlog. Our focus on processing these complex claims contributed to a larger claims backlog, but it remains the right thing to do for our Vietnam veterans, many of whom waited a long time for these benefits. Secretary Shinseki also made an important decision to simplify the process to file claims for combat PTSD. These decisions expanded access to benefits for thousands of veterans and brought significantly more claims into the system.

Several other factors have contributed to this growth in the volume of incoming claims: extensive outreach; increased demand as a result of 10 years of war; improved access to benefits through the joint VA and DOD Pre-Discharge Programs; and new regulations for processing claims related to gulf war service and traumatic brain injuries.

In addition, the average claim in VA's workload is getting more complex. The number of medical conditions (issues) per original claim for our returning Iraq and Afghanistan veterans increased dramatically, from 6.4 at the beginning of fiscal year 2007 to 11.5 at the end of fiscal year 2012. The total number of issues processed increased 180 percent, from 1.7 million in fiscal year 2009 to 4.8 million in fiscal year 2012.

VBA's goal is to process all claims within 125 days with 98-percent accuracy in 2015, and we are confident that we will meet this goal as we continue to implement our Transformation Plan.

Question. As I understand it, VA Dependents Indemnity Compensation (DIC) claims previously were decided at the local and State level, but are now, in the case of Kentucky, decided in Milwaukee, Wisconsin. This has reportedly resulted in longer wait times for veterans' spouses and dependents to receive their claims. What caused the initial decision to relocate this particular DIC claims processing office and what steps is the VA taking to reduce the time it takes to make final DIC claims decisions?

Answer. In fiscal year 2003, VBA completed the consolidation of pension maintenance work to three regional Pension Management Centers (PMC): Philadelphia, Pennsylvania; St. Paul, Minnesota; Milwaukee, Wisconsin. In fiscal year 2009, VBA subsequently consolidated the processing of pension, DIC, and burial benefit claims at the PMCs. The consolidation provides greater processing efficiency and specialization for these claims and focuses attention and resources on the needs of survivors and wartime veterans who require supplemental income.

Fiscal-year-to-date through the end of April, the average days to complete (ADC) DIC claims was 156 days. By way of comparison, for fiscal year 2007, ADC for DIC claims was 132 days. Although ADC for DIC claims has increased since consolidation (18.2 percent), ADC for all types of compensation and pension claims has increased nationwide over this period due to the dramatic growth in the volume of incoming claims.

VBA's Pension and Fiduciary (P&F) Service, which administers the DIC program, recently reviewed the policies and procedures applicable to the adjudication of DIC claims, to identify obstacles to timely processing. It determined that VBA could quickly grant many DIC claims with little or no additional development, and that certain claims processing steps are redundant and appropriate for elimination.

As a result of these efforts, on March 22, 2013, P&F Service issued Fast Letter 13–04 (FL 13–04), Simplified Processing of Dependency and Indemnity Compensation (DIC) Claims, which instructs VBA field staff on the procedures to follow when processing claims. Among other things, the new procedures require screening of claims at the intake point and limited or no development of additional evidence when information in VBA systems supports granting benefits. It also clarifies that VBA grants DIC under 38 U.S.C. section 1318 based upon total service-connected disability for a prescribed period before death in the same manner as if the death were service connected. Accordingly, in these cases, our field staff will grant service-connected burial benefits and presume the permanence of total disability for purposes of establishing the survivor's entitlement to VA education and healthcare benefits. These new procedures will allow us to grant DIC benefits faster and without unnecessary development.

Question. What is the VA doing to enhance efforts to locate homeless veterans and to provide resources and programs to help them?

Answer. One of the key pillars of VA's Plan to End Homelessness Among Veterans is to provide effective outreach to homeless and veterans at risk of homelessness. Without effective outreach efforts locating homeless and at-risk veterans, VA has little chance of ending veteran homelessness. Although many VA homeless programs conduct outreach, the HCHV Contract Residential Treatment Program is VA's premier homeless outreach program. The foundation of the program is to provide targeted outreach to veterans who are homeless or at risk of homelessness and not currently receiving VA services. These outreach efforts are an essential component of VA's plan to eliminate homelessness among veterans and provide opportunities for critical medical and psychiatric care and referrals. Once identified and effectively engaged within their own communities, homeless veterans can then be provided with both immediate and permanent stable housing solutions and supportive services.

In fiscal year 2012, HCHV staff conducted outreach and provided outpatient services to over 119,660 veterans and offered more than 11,500 episodes of contract residential community-based treatment. Outreach has proven to be a successful link, as overall data findings suggest that more than 90 percent of the veterans engaged with HCHV received VA mental health services (including direct services provided by the HCHV Contract Residential Treatment Program) in the 6 months following outreach.

The HCHV Contract Residential Treatment Program works in collaboration with other VA programs through a combination of outreach, case management, housing, and supportive services. The program collaborates with a multitude of VA homeless programs including, the Housing and Urban Development—VA Supportive Housing (HUD–VASH) Program, GPD Program, Veterans Justice Outreach (VJO) Program, Health Care for Reentry Veterans (HCRV) Program, Homeless Veteran Supported Employment Program, Homeless Patient Aligned Care Teams (HPACT) as well as community outreach providers (e.g., 100,000 Homes Campaign, Projects for Assistance in Transition from Homelessness (PATH) Program, and local homeless Continuums of Care (CoC)).

In addition to the HCHV Contract Residential Treatment Program, a number of VA homeless programs contribute to extensive and effective outreach. For example, each year VA programs and staff actively participate in stand downs for homeless veterans. Stand downs are collaborative events, coordinated between local VA facilities, assorted Government agencies, and community agencies that serve the home-

less. The original stand down for homeless veterans was modeled after the stand down concept used during the Vietnam war to provide a safe retreat for units returning from combat operations. Stand downs provide services to homeless veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment, and substance abuse treatment. In 2012, VA-sponsored 205 stand downs nationally, serving over 50,000 veterans.

VA's outreach efforts also include the National Call Center for Homeless Veterans (NCCHV), a program dedicated to providing homeless veterans with referrals to VA and community services, as well as disseminating information to concerned family members and non-VA providers about all the programs and services available to assist these veterans. Calls to the NCCHV number (1–877–4AID VET; 1–877–424–3838) are answered 24 hours a day, 7 days a week, with a brief screening by responders to determine the severity of need. Responders at the NCCHV then link those callers needing referral to their nearest VA medical center (VAMC) anywhere in the country. VAMC homeless programs have designated points of contact responsible for assisting veterans referred to their facility, furthering assessment of need, providing linkages to services within VA and the community, and developing a plan of care appropriate for each veteran. In fiscal year 2012, there were 80,558 total calls to the NCCHV. Of these calls, there were 50,608 referrals to a VAMC homeless program point of contact.

VA's Veterans Justice Programs (the HCRV and VJO Programs) also provide extensive and crucial outreach to veterans involved with the justice system to prevent veteran homelessness. The HCRV Program staff conducts outreach to veterans who are preparing to reenter the community from State and Federal prisons. The goal of this clinical outreach is to connect veterans at risk of homelessness with appropriate VA services, especially homeless, mental health, and substance use services. In fiscal year 2012, the HCRV prison outreach clinicians contacted and conducted re-entry planning with 10,572 veterans in 1,000 of 1,254 (80 percent) total State and Federal prisons. Similarly, VJO program specialists provide outreach to justice-involved veterans in jails and court systems and serve as liaisons between VA and the local criminal justice system, including law enforcement. Every VAMC has at least one full-time VJO specialist. In fiscal year 2012, 27,251 veterans were seen by VJO Program staff.

VA uses all available resources to locate and identify the need for homeless services in each State and community. VA and HUD continue to collaborate, develop, and publish HUD's AHAR. These reports, which advance the Federal effort to end homelessness among veterans through the collection and analysis of timely data, are intended to provide policymakers, practitioners, and the general public with information about the extent and nature of veteran homelessness. In addition to the snapshot and annual estimates of veteran homelessness, the document also describes the demographic characteristics of homeless veterans, including race, ethnicity, gender, age, and disability status.

Finally, VA continues to develop innovative ways to locate and engage veterans at-risk of homelessness, including developing a more proactive approach to identifying those who are homeless or at risk of becoming homeless. In 2012, VA developed a universal screen of homelessness risk for veterans in the VA healthcare system. The Homelessness Screening Clinical Reminder serves veterans by identifying those who may need housing-related assistance but had not accessed or are not currently being served in a VA homeless program. It also provides additional information about the profile of veterans who are at risk of homelessness, the types of services they need and receive, and how veteran homelessness can be better addressed throughout VA's system. To date, over 2.7 million veterans have been screened using this clinical reminder. Of those screened, 25,881 (0.95 percent) screened positive for housing instability and 30,707 (1.12 percent) screened positive for being at risk for homelessness. A total of 17,309 veterans agreed to referrals for social work services who provided veterans with benefits assistance, counseling, and, where appropriate, referral to homeless programs. Through this process, 14,895 veterans were referred to homeless programs.

Question. Veterans suffer from many health problems due to their brave service and sacrifice. I have heard from Kentucky veterans that do not live near VA hospitals or full medical centers that access to certain healthcare services remains a concern for many. What criteria are involved in determining which VA clinics provide specialty care, such as access to mental health resources, podiatry, ophthalmology, and dentistry?

Answer. A VA medical center's process for determining sites of care for services, including specialty care, begins with the annual completion of the VA Health Care Planning Model. On a regular basis, a review of the number of days it takes to pro-

vide specialty services to all veterans is performed, with an emphasis on those in remote or rural areas. VA medical centers also review the frequency with which it refers veterans outside VA's system for services not currently available and the distance from a veteran's home he/she may have to travel to determine potential service additions at their CBOCs. Finally, VA medical centers utilize community providers to augment its healthcare system when it cannot provide those services in-house or within a specified timeframe. Generally, specialty services such as podiatry, ophthalmology, or dentistry services are not provided at CBOCs due to their small size (less than 10,000 unique patients). Specialty mental health services for PTSD, military sexual trauma, and substance abuse are available in CBOCs and by telemental health to a clinic closest to the veteran's home.

Question. Many veterans face difficulty beginning families when they return from service, particularly those who have sustained injuries such as spinal cord injury or disorder (SCI/D). Is reproductive assistance a standard VA medical service provided to veterans with service-connected injuries? What is the VA doing to address the needs of veterans seeking reproductive assistance? Does the VA need additional legislative authority to provide reproductive services?

Answer. As part of the medical benefits package, VA provides infertility services to include patient counseling, infertility assessment, and infertility treatment. When medically indicated, VHA will provide the following infertility services:

Infertility services for female veterans	Infertility services for male veterans
—Infertility counseling	—Infertility counseling
—Laboratory blood testing (e.g., follicle-stimulating hormone, luteinizing hormone)	—Laboratory blood testing (e.g., serum testosterone)
—Genetic counseling and testing	—Semen analysis
—Pelvic and/or transvaginal ultrasound	—Evaluation and treatment of erectile dysfunction (e.g., in spinal cord injury)
—Hysterosalpingogram	—Surgical correction of structural pathology
—Saline infused sonohysterogram	—Vasectomy reversal [1]
—Endometrial biopsy (e.g., rule out a luteal phase defect)	—Hormonal therapies
—Post coital test	—Sperm cryopreservation [1]
—Diagnostic laparoscopy or hysteroscopy	—Genetic counseling and testing
—Surgical correction of structural pathology consistent with standard of care including operative laparoscopy and operative hysteroscopy	—Sperm retrieval techniques
—Reversal of tubal ligation (Tubal Reanastomosis) [1]	—Post-ejaculatory urinalysis
—Hormonal therapies (Controlled ovarian hyper-stimulation)	—Transrectal and/or scrotal ultrasonography
—Oral medication for ovulation induction (i.e., Clomid/Serophene) (maximum of 4 ovulatory cycles)	
—Injectable Gonadotropin Medications for ovulation induction	
—Additional hormonal therapies approved for use for this purpose by Pharmacy Benefits Management	
—Intrauterine insemination (maximum of 4 cycles)	
—Oocyte cryopreservation	

[1] For medically indicated conditions.

The provision of In Vitro Fertilization (IVF) is excluded from VA's medical benefits package. Also, infertility diagnosis and management is a condition of couples. VA has limited authority to provide services to non-veterans; however, in accordance with title 38, Code of Federal Regulation (CFR) 17.272(a)(28), IVF is specifically excluded for coverage under Civilian Health and Medical Program of VA.

Most male veterans with spinal cord injuries or disorders (SCI/D) have erectile dysfunction and infertility directly related to spinal cord dysfunction. Available options for the evaluation and treatment of infertility in veterans with SCI/D are limited. A full diagnostic evaluation is provided. Treatment that is available in VA includes approaches such as surgical correction of structural pathology, hormonal therapies, sperm retrieval and cryopreservation, and intrauterine insemination. In the vast majority of men with SCI/D, VA treatments that are provided do not result in successful pregnancies. Infertility services, including IVF and other Assisted Reproductive Technologies (ART), restore or enhance the ability to procreate, but successful treatment requires the provision of ART services to both the ill/injured veteran and his or her spouse/partner. Currently and in the past, VA has worked with DOD and community partners to identify resources that are available for veterans with SCI/D.

QUESTIONS SUBMITTED BY SENATOR SUSAN M. COLLINS

Question. Secretary Shinseki, I spoke with you last August about my disappointment with the wasteful conference spending and improper behavior by Department of Veterans Affairs (VA) employees related to two VA conferences held in Orlando, Florida, in 2011. More than $6.1 million was spent on these two conferences, and the VA Office of Inspector General (OIG) found that as much as $762,000 was unauthorized, unnecessary or wasteful spending.

I share your belief that effective training of VA personnel—the purpose for the conferences—is necessary. Despite the legitimate purpose of training, there can be no excuse for excessive or wasteful spending of VA resources. I know that you share my concerns about wasteful spending, especially in these challenging fiscal times, and that you agree that at a time when so many veterans are in need of care and assistance, the VA must make every effort to spend each dollar in support of its important mission.

What steps has the VA taken to prevent similar waste and abuse of Government resources in the future?

Answer. VA employs over 320,000 employees who provide high-quality healthcare, benefits, and services to veterans every day. VA is the Nation's largest integrated healthcare system with nearly 1,300 centers of care serving 8.6 million veterans across the country. A large number of VA doctors, nurses, claims processors, and other employees directly benefit from training events every year. Continuous workforce training and development is essential to delivering timely and quality VA care and services our veterans have earned and deserve. VA holds centralized training forums to enhance the delivery of healthcare, benefits, and memorial services unique to veterans. This includes employee development through critical training to improve customer service and the timely delivery of benefits and services; clinical training, which includes post-deployment care, treatment of chronic conditions, mental health, suicide prevention; and strategies to eliminate veteran homelessness. Our training events are designed to achieve our goals—better access, eliminate the backlog, and end veteran homelessness—by training and developing our employees and empowering them to provide the best care and services possible for our Nation's servicemembers and veterans.

VA has implemented a comprehensive action plan to revise and strengthen policies and controls on the planning and execution of training conferences and events. These actions are consistent with the recommendations in the September 30, 2012, inspector general report and are reflected in VA policy issued on September 26, 2012.

Stringent internal controls for training conferences are in place and oversight is provided by the senior executives in the Department. Further, the newly established Training Support Office ensures consistency and clear guidance regarding needed steps for adherence with all appropriate regulations and requirements as the Department balances critical training requirements to ensure achievement of stated goals and objectives while minimizing costs.

Automating data collection is essential to provide accurate and timely information for senior leaders so they can execute their responsibilities and respond to queries for training related events from congressional and other Federal oversight bodies. VA is currently engaged in developing and delivering an automated data collection tool to increase accountability, control conference spending, and produce congressionally required reports.

VA's conference oversight memorandum dated September 26, 2012, supersedes all previously issued conference guidance:

—the approval authorities:
  —a senior executive must approve any conference under $20,000.
  —two senior executives, the Conference Certifying Official (CCO) and the Responsible Conference Executive (RCE), are appointed when a conference exceeds $20,000 to ensure adherence to all applicable statutes, regulations, and policies when planning and executing the approved conference.
  —an Under Secretary or Assistant Secretary must approve any conference within the threshold $20,000 to $100,000.
  —the Deputy Secretary is responsible for approving conferences exceeding $100,000 to $500,000.
  —conferences exceeding $500,000 require a waiver by the Secretary.
—a quarterly conference planning and execution briefing is now required at least 120 days prior to the quarter of execution. This briefing outlines all the conferences planned for the targeted quarter to include cost, attendees, location, purpose, and outcomes.

The VA conference process has four phases: concept, development, execution, and reporting.

—The concept phase is a disciplined conference authorization process. In October 2012, VA began our quarterly concept authorization briefing as part of the quarterly conference planning and execution briefing cycle where senior officials review all events to ensure the best value prior to being authorized to enter the development phase.

—The development phase builds the business case for the event; provides the guidance for the planning and execution of the potential conferences; appoints a senior executive as the CCO and a senior executive as the RCE. The CCO certifies the event details are in compliance with all directives. The event plan is then submitted through the appropriate channels to the approving official for approval, disapproval or modification of the planned event.

—The execution phase covers the period after the conference plan has been approved and the responsible organization begins to execute the approved plan. The RCE is responsible for executing the approved plan in accordance with laws, regulations, and policy. Additionally, the RCE oversees the spending and contract execution, approving any changes to contract agreements or increases in spending.

—The reporting phase covers the period after the execution of the conference. The RCE submits an After Action Review (AAR) reflecting how the event was conducted; providing conference attendance and details on how the spending was tracked and reported in accordance with Public Law 112–154 and OMB M–12–12. The administrations and staff offices leadership review the AAR to verify that the event was executed in accordance with the plan and all applicable policies and regulations.

QUESTIONS SUBMITTED BY SENATOR DANIEL COATS

CLAIMS PROCESSING

Question. The President's fiscal year 2014 budget calls for an 8.5-percent increase in funding for the Department of Veterans Affairs from fiscal year 2012. The administration justifies this increase in funding in order to reach a target goal to "process all claims within 125 days with 98-percent accuracy in 2015." The average wait time in Indianapolis is 600 days.

With even more servicemembers entering the VA system in the next year, as we drawdown from Afghanistan, how feasible is this goal?

Answer. Right now, too many veterans wait too long to receive benefits they deserve. This has never been acceptable to VA or to the dedicated employees of VBA—52 percent of whom are veterans themselves. In January 2013, VA delivered its Strategic Plan to Eliminate the Compensation Claims Backlog to Congress (http://benefits.va.gov/transformation/docs/va_strategic_plan_to_eliminate_the_compensation_claims_backlog.pdf). We are confident that we will meet our 2015 goal as we continue to implement our Transformation Plan. While the troop drawdown may result in an influx of new claims, VBA has anticipated this workload and considered its impact on VBA's ability to reach the 2015 goals. It is important to note that the timeline for eliminating the backlog could be affected if policymakers establish new presumptive conditions, courts make new precedential decisions, or legislators make laws that establish new entitlements. VBA continues to monitor the performance impact of transformation, as well as other external factors that could potentially have an impact.

Question. What specific actions has the Department of Veterans Affairs taken to reach this goal?

Answer. VBA has developed and is implementing a comprehensive Transformation Plan designed to eliminate the claims backlog and achieve our goal of processing all claims within 125 days at a 98-percent accuracy level in 2015. This major transformation in claims processing includes a series of people, process, and technology initiatives that are being implemented according to a carefully developed multiyear timeline. The transformational initiatives are being rolled out in a progressive, deliberate sequence that enables efficiency gains while minimizing risks to performance.

VBA reorganized its workforce into cross-functional teams that enable employee visibility of the end-to-end case management approach of the entire processing cycle of a veteran's claim. These cross-functional teams work together on one of three segmented lanes: express, special operations, or core. VBA instituted Challenge Training in 2011 and Quality Review Teams (QRT) in 2012 to improve employee training

and quality while decreasing rework time. Challenge Training is focused on overall skills and readiness of the workforce, and QRTs focus on improving performance on the most common sources of error in the claims processing cycle; data on VBA's largest sources of error are captured and analyzed by its National Accuracy Team. VBA tracks the impact of these initiatives on quality through a 3-month rolling average accuracy metric that is reported on VA's ASPIRE Web site and can be found online at http://www.vba.va.gov/reports/aspiremap.asp.

VBA actively solicited innovative ideas for process improvement from veterans, employees, and industry stakeholders through a variety of structured mechanisms. Literally thousands of ideas were received and culled down to those with the largest potential to attack the backlog. For example, automated Disability Benefits Questionnaires (DBQ) (discussed below)—arguably one of the most highly leveraged changes—came from one of the VBA employee idea competitions. Additionally, VBA has also conducted Lean Six Sigma and Kaizen events on these selected targets of opportunity, all focused on five major areas of focus: wait time, rework, productivity, digital intake, and variance.

VBA also implemented the simplified notification letter initiative. This initiative has reduced key strokes and automated production language in the decision letter for the veteran, thus improving rating decision productivity and quality. VBA implemented this initiative on March 1, 2012.

Electronic DBQs are forms that physicians complete during an exam that contain explicit medical information needed to decide a disability compensation claim. The single largest category for rework that results in delays in rating decisions are exams that contain insufficient data. Fully and properly complete DBQs eliminate these errors. The DBQs, now deployed to all 56 regional offices, can increase production and reduce the amount of time spent on each claim by organizing key information. Seventy-one DBQs are now available to private physicians as well. VBA continues to work with DOD regarding the use of DBQs in exit exams.

Key to VBA's transformation is ending its reliance on outmoded and paper-intensive processes. VBA is developing technology solutions that improve access, drive automation, reduce variance, and enable faster and more efficient operations. The deployment of the VBMS, VBA's new digital, paperless processing system, is occurring across four distinct phases or generations of development. Generation One of VBMS concluded with the successful implementation of Release 4.1 in January 2013. This generation culminated in a foundational Web-based, electronic claims processing solution. Under our accelerated deployment schedule, all 56 regional offices and our Appeals Management Center are now using VBMS. We will also continue to enhance the automated functionalities and build additional system capabilities in three future generations of VBMS to be deployed over the next 2 years. As we move into future generations of VBMS, our focus is on leveraging more complex automation features and more extensive data exchange and system integration capabilities so that our employees will be able to process claims electronically from receipt to payment.

Question. What actions will be taken in the future to make sure our brave men and women are not waiting nearly 2 years to get a reply from the VA?

Answer. VA's goal of processing claims within 125 days with 98-percent accuracy is a permanent goal. Our Transformation Plan, which incorporates people, process, and technology initiatives, will ensure that the backlog is resolved and that the results are sustained and continuously improved upon.

VBA's new organizational model, which incorporates a case-management approach to claims processing, has been implemented at all 56 regional offices. VBA projects that the segmented lanes initiative, part of this new organizational model, will accelerate simpler claims, predictably taking less time through the express lane, with the remainder of claims flowing through either a special operations lane (claims requiring special handling) or core lane. This segmented, case-management approach to claims processing is creating efficiencies within our workforce.

Under our accelerated deployment schedule, all 56 regional offices and our Appeals Management Center are now using VBMS. Once fully developed, VBMS is projected to provide a 20-percent increase in productivity, or an estimated increase in production of over 200,000 claims in fiscal year 2015.

Future generations of VBMS will focus on continuing to improve electronic claims processing by providing increased system functionality and more complex automation capabilities for all VBMS end-users. VBA, in collaboration with the Office of Information and Technology, is building new decision-support tools to make our employees more efficient and their decisions more consistent and accurate. We have already developed rules-based calculators for disability claims decisionmakers to provide suggested evaluations. For example, the hearing loss calculator automates deci-

sions using objective audiology data and rules-based functionality to provide the decisionmaker with a suggested decision.

VBA's partnership with Veterans Service Organizations (VSOs) is also crucial to our transformation. Today, only about 5 percent of claims received by VA come with the documentation necessary for a decision. As a result, VBA reviewers commit countless hours attempting to locate medical and service records, and arranging physical examinations needed to support veterans' claims. VBA is greatly expanding education and collaboration efforts with VSOs that result in the submission of more "fully developed" claims (FDC) (http://benefits.va.gov/transformation/fastclaims/)—claims that come to VA ready for final review and decision.

VBA is also completing the integration with other Federal departments that enables inter-departmental data review and exchange to support pension and disability claims processing. This includes the Social Security Administration, Internal Revenue Service (income verification), and the Department of Defense (military personnel and medical records). Currently, claims take an average of 314 days to process, and approximately 239 of those days are taken up in the process of gathering information from other sources.

PATIENT CENTERED COMMUNITY CARE (PCCC) PROGRAM

Question. There are concerns from local healthcare providers that the VA is not properly communicating the new Patient Centered Community Care (PCCC) Program. For example, last September, the public was given only 2 weeks to provide comments/suggestions to the VA's request for proposal for the PCCC Program—this was not nearly enough time to assess the impact of the implementation of PCCC nor was it enough time for the 5,000-page program to be understood by the healthcare providers who serve our veterans.

Do you think there should have been a larger window for that comment period to improve transparency?

Answer. While we realize that not everyone in the community responded with questions and comments, we believe ample time was provided. We began our market research in 2011 with a Request for Information (RFI) posted to Federal Business Opportunities (FedBizOps), which allowed anyone in industry to respond to questions designed to help guide the program's development. We also conducted Industry Day events in Portland, Oregon, Minneapolis, Minnesota, and Atlanta, Georgia, in November and December 2011 to allow anyone in the community to attend and hear our plans, ask questions, and have one-on-one time with the program team and contracting officers.

A draft Request for Proposals (RFP) was released in September 2012 that allowed time for community/industry providers and companies to see the actual requirements we planned to release and to provide comments or ask questions. The final RFP was released in December 2012. Through extensions, the RFP comment and question period was prolonged to March 6, 2013. From the time of the original RFI in November 2011 to the extended RFP comment period, March 6, 2013, the program team, through the contracting officer, was open for discussion and comments and also held multiple briefings with U.S. House of Representatives and U.S. Senate congressional staff.

One of the attachments to the 114-page RFP added a number of pages to the overall solicitation, but this data is intended to show the types and volumes of care we have purchased historically. This information was requested by industry so they could get a sense of care purchased in the past and assist them in planning network development. We assume the reference to 5,000 pages includes a printed version of the fiscal year 2010–2012 data spreadsheet.

Question. Second, what are your opinions on requiring a minimum length for an open comment period for a proposal of this significance?

Answer. Federal Acquisition Regulations (FAR) requires the agency to establish a response time for commercial item acquisition that will afford offerors a reasonable opportunity to respond. For non-commercial item acquisitions, a minimum of 30 days is required by FAR. The time allotted for offerors to respond with a proposal to the PCCC RFP exceeded 30 days. With each amendment and extension of the proposal submission timeline, open periods for comments and questions were allowed. The final date range from initial RFP release to receipt of proposals, after all amendments, is December 21, 2012, to May 28, 2013.

There appear to be many concerns from healthcare providers about the Patient Centered Community Care Program (PCCC). For example, healthcare providers are worried their existing contracts will be allowed to expire and replaced and the VA will prohibit contracting with long-term care hospitals and hospice. Furthermore, some are under the impression PCCC will require veterans in rural areas needing

hospital level care to travel up to four hours or more to receive care even if care is available in the veteran's community but it is not a PCCC hospital.

Question. What specific communications strategies has the VA implemented to address these questions from the public and better inform them on these complex provisions stemming from PCCC.

Answer. Through the draft RFP and final RFP comment and question process, we responded to any questions asked about local contracts and provided these answers in amendments posted to the RFP on FedBizOps. This follows normal acquisition procedures. Furthermore, we provided a fact sheet to congressional staff and followed up with briefings and open general sessions, including:

—holding a Four Corners briefing with the House and Senate Veterans' Affairs Committees in January;

—responding to an inquiry from the Senate Budget Committee;

—holding general session Non-VA Medical Care Contracting 101 briefings for House and Senate staff;

—briefing, in February and April 2013, the Senate Appropriations Committee; and

—briefing, in May 2013, the House Appropriations Committee.

VA is not restricting local VA medical centers from contracting through the Federal acquisition process. Those community providers wishing to support or continue supporting veterans through PCCC can participate in an awarded contractor's network. Please note long-term care and Hospice are not included in PCCC; therefore, these existing contracts are not impacted in any way.

Through contracts awarded as a result of PCCC procurement, we will be able to partner with networks of community providers that already have existing facilities in rural and highly rural areas that will be available to our veterans when VA determines they should receive the needed care in their communities. If the contracted partner does not have a facility within reasonable range of the veteran's home, individual authorizations are available to allow VA to furnish the care from community providers not under the PCCC contract.

The Patient Centered Community Care Program (PCCC) does not utilize the most current quality outcome measurement tools, such as value based purchasing used by Medicare. Instead, the RFP creates three quality review committees looking at publicly available data instead of requiring an outcome measurement system.

Question. Why doesn't the VA include state-of-the-art patient outcome measurement requirements of its contractors?

Answer. The PCCC RFP includes quality requirements established by VA clinical providers and management. A key principle in the PCCC process is to get medical diagnostic and treatment information back to VA care teams so that a veteran's care is managed and less fragmented than can often occur outside VA. Requirements developed include: timeliness for the return of medical documentation, credentialing, privileging, licensure, board certification, medical documentation, and safety reporting. The RFP also includes performance measurement requirements specifically around surgical outcomes and cardio-thoracic procedures that are not publicly available.

The requirement for Peer Review and Quality Oversight Committees is a positive lesson learned from VA's Project HERO pilot in which our partners had these committees as standard network operations. Operationally, medical staff review patient/episodic quality cases to ensure patients are protected and receiving high-quality levels of care. The Peer Review Committee is responsible for reviewing provider standards of practice while the Quality Oversight Committee reviews access, patient satisfaction, and performance standards. Most commercial networks have existing medical officers and quality committees to provide oversight of their networks. It is in the best interest of VA to follow these community practices and benefit from quality activities already in place in the business community. The requirement for VA to be allowed to participate in these committees enhances our assurances of the provision of quality care so we are not delegating or abdicating quality oversight to the contracting networks.

Publicly reported data will be sent to VA after acceptance by the requesting organizations; VA will receive and evaluate that data versus asking the contracted partner to have a subcommittee to accomplish that activity. Our desire is to create partnerships that will leverage existing valid quality management programs to enhance patient quality, safety, and access to care. Additionally, as the Centers for Medicare and Medicaid Services move toward full implementation of pay for performance initiatives, VA will seek ways to collaborate and apply these pay for performance initiatives to the care purchased for veterans. The development of healthcare networks is a dynamic process; as hospitals and healthcare providers are recognized as excep-

tional performers, VHA can request potential recruitment of said performers into the existing provider network.

QUESTIONS SUBMITTED TO RICHARD J. GRIFFIN

QUESTION SUBMITTED BY SENATOR TIM JOHNSON

VA–DOD COOPERATION

Question. In the VA budget submission, information technology oversight was listed as one of the major program challenges for the inspector general. The VA–DOD integrated Electronic Health Record, or iEHR, is certainly a major IT initiative. Being a joint agency project no doubt presents oversight challenges. But it is top priority of both the VA and DOD Secretaries, and essential to the seamless transition of health records for veterans.

I am very concerned about the direction of this initiative given recent indications that the two agencies may drop plans for a joint system in favor of separate systems with file-sharing capabilities. It appears that soaring costs and time considerations played a major role in this change of course.

What is the VA inspector general planning to do to monitor the cost, development timeline, and likelihood to meet program goals of the iEHR?

Answer. The status of the integrated Electronic Health Record (iEHR) is currently in a state of uncertainty; as a result, we consider it premature for the VA Office of Inspector General (VA OIG) to undertake an assessment of the initiative at this time. We understand that the Government Accountability Office is currently reviewing this issue.

VA continues with efforts to modernize the Veterans Health Information Systems and Technology Architecture—its "core" system for the iEHR initiative. The VA OIG will continue to monitor decisions made regarding the iEHR so that we can review this system development initiative when the timing is right. We will then initiate an audit focusing on the VA perspective as the VA OIG's oversight authority does not cross departmental lines.

QUESTION SUBMITTED BY SENATOR MARK BEGICH

MENTAL HEALTH CARE IN RURAL AREAS

Question. Mental health continues to be a concern in rural areas, access, wait times, etc. Can you tell me in your inspections, if contract mental health is being utilized to the full extent and what are your recommendations to expand?

Answer. Our inspections indicate that VA struggles to provide access to mental health services to veterans across the United States. VA has the ability to utilize non-VA care (also known as fee basis) and contract programs to provide healthcare to supplement the care VA is able to provide through its own facilities. VA needs to institute contract and fee basis agreements to permit timely and coordinated mental healthcare for veterans who would benefit from these services. Better coordination with State and local government mental health officials, who often support community mental health services, and with private mental health providers has the potential to dramatically improve the access to mental health services by veterans.

SUBCOMMITTEE RECESS

Senator JOHNSON. This hearing is recessed.

[Whereupon, at 4:31 p.m., Thursday April 18, the subcommittee was recessed, to reconvene subject to the call of the Chair.]