

**MILITARY CONSTRUCTION, VETERANS AFFAIRS,
AND RELATED AGENCIES APPROPRIATIONS
FOR 2017**

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTEENTH CONGRESS
SECOND SESSION

SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS,
AND RELATED AGENCIES

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CONTENTS

HEARINGS

	Page
Veterans Affairs Office of Inspector General	1
Veterans Affairs Budget	67

DEPARTMENT OF VETERANS AFFAIRS JUSTIFICATIONS

Fiscal Year 2017 Budget Submission—Budget in Brief	199
Fiscal Year 2017 Budget Submission—Summary Volume 1	243
Fiscal Year 2017 Budget Submission—Summary Volume 2	361

RELATED AGENCIES JUSTIFICATIONS

American Battle Monuments Commission	803
Arlington National Cemetery	835
U.S. Court of Appeals for Veterans Claims	857
Armed Forces Retirement Home	883

DEPARTMENT OF THE AIR FORCE JUSTIFICATION

Military Construction Program Documentation fleet changes the Fiscal Year 2017 Justification for CNMI Land Acquisition and European Reassurance Initiative Requests submitted June 2016	917
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MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR 2017

THURSDAY, FEBRUARY 25, 2016.

OVERSIGHT HEARING—VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

WITNESSES

LINDA A. HALLIDAY, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

JOHN DAVID DAIGH, JR., MD, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, DEPARTMENT OF VETERANS AFFAIRS

CHAIRMAN OPENING STATEMENT

Mr. DENT [presiding]. Thank you, everybody, for being here this morning. I am pleased to call to order our first hearing in the fiscal year 2017 cycle.

What topic could be more appropriate to start with than oversight?

Taking to heart Ranking Member Bishop's suggestion, today we are pleased to welcome deputy inspector general of the Department of Veterans Affairs, Linda Halliday. Mrs. Halliday is a well-known figure to us since the I.G.'s office has been very involved in investigating and auditing many of the VA problems that confront us in daily headlines.

She is accompanied by Dr. John Daigh, of the Office of Healthcare Inspections.

Before we get underway, I want to remind Members of our traditional hearing rules. For those Members present in the room when I gavel in the beginning of the hearing, I will recognize you for questions in order of seniority, alternating between majority and minority. For those of you who arrive after the hearing has started, I will recognize you in order of arrival, alternating between majority and minority.

This order will continue through all the rounds of questioning. I intend to observe the 5-minute rule for questions and answers. The goal is to have more opportunity for all of you to ask questions and hear from witnesses, so if we keep the proceedings moving we stand a better chance of accomplishing that.

And before I recognize Mrs. Halliday, I will be asking Ranking Member Bishop if he has any opening remarks.

And I would also like to acknowledge the presence of Sam Farr, who is retiring. And he has been a longtime member of this full

committee and, of course, this subcommittee. He has been a very diligent and thoughtful Member, and we will miss him.

So with that, I would like to recognize Mr. Bishop.

Mr. BISHOP. Thank you very much, Mr. Chairman for yielding.

RANKING MEMBER STATEMENT

I believe that the inspector general's major advisory role is assuring that programs that are implemented actually work and that funding is spent wisely. That is the task and has been a difficult thing to do over the past few years—a couple of years ago I believe you were tasked with investigating the scandal in Phoenix, to which we were all appalled. In response to this investigation, which uncovered numerous issues, Congress moved forward on historic legislation, the Veterans Choice Act, and now you have to provide oversight of the program.

Furthermore, you have had to look into what happened with the Denver Medical Center. Therefore, in addition to your normal duties you have had some pretty big-ticket items on your plate.

I believe that it is critical for the inspector general to have the necessary resources so you are able to conduct the aggressive oversight to assure that veterans are able to receive the health care they need and when they need it. It is vital that we change the culture that has taken hold in VA and to make sure that it is not able to resurface.

So no matter what the steps that VA takes to address the challenges it faces in delivering health care, VA will not be able to move forward if we don't have proper oversight, and you play a vital role in that oversight in assisting us in our duties.

So I commend the work that has been done over the past few years. There is a lot yet to be done to repair the trust in our VA, and I look forward to working with the chairmen and members of this subcommittee to eliminate the issues that have been raised by your office.

And we thank you.

And I yield back.

And before I yield, let me also just join the chairman in giving accolades and saluting our colleague, Mr. Farr, who has served very diligently on this committee and others. And, of course, he has an abiding love and dedication to veterans. And we are going to miss him, but enjoy, and look forward to continuing to benefit from his pearls of wisdom as we finish this process.

With that I yield back, Mr. Chairman.

Mr. DENT. Thank you. Thanks, Mr. Bishop.

And at this time, Mrs. Halliday, I would ask you to introduce your colleague, and then we would be pleased to hear a summation of your written testimony, which will be entered into the record. So thank you, Mrs. Halliday. The floor is yours.

MRS. HALLIDAY OPENING STATEMENT

Mrs. HALLIDAY. Mr. Chairman and members of the subcommittee, thank you for the opportunity to discuss the budget request for fiscal year 2017. I am accompanied by Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections.

I also have with me my Assistant Inspectors General in my other line offices: Quentin Aucoin, Gary Abe, and Dana Moore. Each of them have helped me assess this budget.

The OIG is responsible for conducting oversight of all VA programs and operations. After assuming the position of the Deputy Inspector General in July 2015, I prioritized developing a realistic budget for the organization, and I am pleased that this budget request represents the largest increase OIG received in the past several years.

From 2009 to 2016, VA's budget grew by more than 70 percent, and that rapid growth represents increased risks of mismanagement and other performance challenges that can result in poor financial stewardship of taxpayer dollars.

To meet our broad mission, the OIG needs to be properly funded and staffed to provide sufficient oversight of new initiatives, revamped programs, and added services and functions resulting from the growth in the department's budget and responsibilities.

There is a stark contrast between our resources and the scope of the mission. In fact, when compared to other large and comparable OIGs, our OIG would rank at the bottom in terms of authorized staffing when compared with other comparable agency budgets.

We appreciate the recognition by the President that the OIG's budget needs to continue to grow in fiscal year 2017, and we would like to acknowledge the support the Secretary gave during the budget formulation process. For fiscal year 2017, the President requested and we hope the Congress will approve \$160,106,000. This will enable the OIG to staff up to 790 full-time employee equivalents (FTE).

The OIG's budget for fiscal year 2016 was \$136,766,000, and we also thank the Congress for the increase of \$10 million over the President's request in 2016. This increase enabled the OIG to bring our staffing levels up to 690 full-time equivalents instead of implementing a potential cut of 10 FTE, as the President's budget would have necessitated.

However, even with the added increase in the fiscal year 2017 budget, the OIG does not have the resources needed to allow for sufficient oversight of VA's growing programs and operations. As a result, we view the fiscal year 2016 budget increase and our 2017 request as a first step in right-sizing the OIG's budget and staffing levels to an appropriate ratio, given the size, scope, and complexity of VA's mission and organization.

This increase will help expand oversight of critical programs and services and allow us to conduct the level of oversight needed to root out potential fraud, waste, abuse, and mismanagement that we think is in some of the programs.

We also need more resources to be more responsive to congressional requests, as congressional requests continue to increase. The increase will support the deployment of additional positions, including health care and benefits inspectors, criminal and administrative investigators, auditors, and other support staff.

We need to take immediate action to increase the number of administrative investigators we currently have. We also need to hire more benefits inspectors.

We need to enable the resources to be available to perform special reviews and examine the effectiveness of VBA's mission-critical processes and support systems. We will focus our attention on VBA's claims processing, especially the workload associated with the non-rating claims and the delays veterans are experiencing in the appeals process.

Increased oversight is needed as VA implements the Choice Act. This is especially important for veterans in rural settings as they face unique challenges to obtain care, and increased oversight over the quality of care provided to veterans reliant upon non-VA providers for their services.

We need increased oversight of major and minor construction. Our hotline received 39,000 contacts in 2014 and over 38,000 in 2015. To date, we estimate we will receive about the same number of contacts.

Every contact we receive requires a certain amount of time and resources to be logged, analyzed, triaged, and processed by staff, regardless of whether the issue is one the OIG can review or whether we need to identify another agency having the legal authority over the matter.

The enormous task ahead requires OIG oversight to ensure that VA processes are in place to protect not only veterans' health but also the tax dollars and their entitlement to benefits.

Since Phoenix became a national issue, our congressional requests have increased over 40 percent. These requests require diverse reviews of multiple clinical areas and address a broad range of quality-of-care issues, and the reviews are generally resource intensive, both in terms of staff and time.

For example, in the last 2 weeks we have been requested to review three major medical centers. We lack the resources to perform all work requested.

We need to strive to examine more systemic-type issues impacting large numbers of veterans so our recommendations drive positive change, such as our recent work on VA's national call centers. Historically, we recover the costs of our operations many times over through a robust return on investment. In 2015 alone, we achieved a 20-to-1 return on investment, which amounted to \$2.2 billion in monetary benefits.

Our OIG needs the appropriate level of funding to provide the necessary oversight. We need and want to be responsive to congressional requests and, most importantly, be responsive and timely reporting on issues that are systemically impacting the delivery of services and benefits to veterans and their families. We can serve a major and distinctive role in ensuring good governance.

Again, I thank the Congress as you begin to process this request because it continues to strengthen our organization. We are currently waiting and excited for the Senate to confirm the nominee for the Inspector General. It has been my privilege to serve as the Deputy Inspector General, and the last 7 months have been filled with many professional challenges for me and the organization.

On behalf of myself and the OIG staff, I can say we are committed to the OIG mission of providing independent oversight of programs and operations in VA. When the nominee is confirmed,

the staff and I are committed to assisting him as he leads and shapes our future organization.

This concludes my statement, and I would be happy to answer any questions.

[The information follows:]

Senior Executive Biography

Linda A. Halliday
Deputy Inspector General

Linda A. Halliday was appointed as Deputy Inspector General of the Department of Veterans Affairs on July 6, 2015, after serving nearly 3 years as the Assistant Inspector General for Audits and Evaluations Division within the Veterans Affairs Office of Inspector General.



As Assistant Inspector General for Audits and Evaluations, Mrs. Halliday directed the national audit and evaluation program, encompassing a network of geographically dispersed field and headquarters staff. Under her leadership, the Office of Audits and Evaluations (OAE) provided oversight to over 150 health care facilities, \$80 billion in veterans' entitlement program benefits paid annually through 56 VA Regional Offices and 150 national cemeteries. During her 23 years with OAE, Mrs. Halliday has successfully led the organization through some of the largest scandals faced within the Federal government and especially within the Department of Veterans Affairs including the alleged deaths of veterans awaiting access to health care services in Phoenix, VA, abuses and mismanagement of VA conferences and the largest information security breach and data loss involving 26.6 million veterans' records.

Working in varied and progressively more responsible positions for 3 decades of public service, Mrs. Halliday has worked at the Department of Veteran Affairs, the Department of Health and Human Services, the Public Health Service, and the Defense Contract Audit Agency. She began her VA career managing financial management activities at the VA Medical Centers in East Orange, NJ, and Brooklyn, NY in 1975. She also served as the Chief Financial Officer for a privately held company.

Mrs. Halliday holds a Bachelor of Science degree in Accounting from the University of Bridgeport (CT) and is currently a Certified Internal Auditor. She also completed the VA's Executive Leadership Program, the Federal Executive Institute's Executive Development Program, and American University's Key Executive Leadership Certificate Program in the School of Public Affairs. In fiscal year 2015, Mrs. Halliday began completing executive development course work at the Harvard Business School and the John F. Kennedy School of Government in Cambridge, MA.

Mrs. Halliday grew up in Bridgeport, CT, and currently resides in Prince William County, VA, with her husband. She has two grown children.

**STATEMENT OF LINDA A. HALLIDAY
DEPUTY INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES**

FEBRUARY 25, 2016

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the work of the VA Office of Inspector General (OIG) and our budget request for fiscal year (FY) 2017. I am accompanied by John D. Daigh, Jr., MD, CPA, Assistant Inspector General for Healthcare Inspections for the OIG's Office of Healthcare Inspections.

BACKGROUND

The OIG is responsible for conducting oversight of VA programs and operations including the delivery of health care services, benefits administration, financial management, and information technology and security. In the last several years, VA has grown significantly due to an increased demand for services by our Nation's veterans, and we expect this trend to continue. In fact, from 2009 through 2016, VA's budget has grown by more than 70 percent.¹ Such rapid growth presents increased risks of management and performance challenges that could result in poor financial stewardship of taxpayer dollars. It also creates a need for the OIG to be properly equipped to provide sufficient oversight of the new initiatives, revamped programs, and added services and functions resulting from this increased spending.

As we said last year, the national attention on VA has led to an increased public awareness of the OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline and in the number of inquiries sent to us by Members of Congress. The OIG Hotline received over 39,000 contacts in FY 2014 and over 38,000 contacts in FY 2015. To date in FY 2016, the OIG Hotline has received 13,240 contacts. This is significant because every contact we receive obligates a certain amount of time and resources to be logged, analyzed, triaged, and processed by staff, regardless of whether the issue is one that the OIG can review or if another agency such as the Office of Special Counsel has legal authority over that matter. Moreover, the OIG does not get involved in veterans eligibility claims decisions so those individuals must be informed to contact VA and specifically the Veterans Benefits Administration (VBA). However, the triage process provides information to our managers regarding possible areas of concern that need to be reviewed.

Of particular concern to the OIG are those contacts alleging substandard quality of care. Because we are not in a position to open a formal inspection for every contact that

¹ <http://www.va.gov/budget/docs/summary/Fy2017-FastFactsVAsBudgetHighlights.pdf>

appears to warrant some level of additional review, we must have a sound process in place to ensure we are dedicating our limited resources to those allegations that in our professional judgment represent the greatest risk of harm to veterans. For example, to determine whether quality of care allegations should trigger a formal inspection, our team of physicians, nurses, and other clinicians consider multiple factors including risk to patients and resource availability. The risk assessment is particularly important and is informed by the relative scope (the number of patients affected) and severity (the actual or potential impact on patients' health or safety) of the alleged quality of care issues.

Because we contend with the stark contrast between our resources and the scope of our mission, we must continually evaluate our business practices to seek greater efficiencies, achieve larger economies, and ensure our actions are providing veterans and taxpayers with the necessary information. We have efforts underway to increase the number of reviews we complete annually. Over the next year, we will enhance our capabilities for tracking and trending Hotline complaints received to better identify issues meriting system-wide review and VA facilities that may benefit from focused OIG oversight.

Historically, we have recovered the costs of our operations many times over through a robust return on investment. In FY 2015 alone, we achieved a 20:1 return on investment, which amounts to \$2.2 billion in monetary benefits. Actual dollar recoveries such as fines, penalties, restitutions, and civil judgments are eventually returned to the U.S. Treasury, and in some instances to VA's Revolving Supply Fund. The return of these funds, collected through the efforts of OIG, provide a considerable benefit to the taxpayer and VA. However, the OIG does not track VA's use of these funds as they are not directly available to support the OIG's requirements.

The OIG's budget for FY 2016 is \$136,766,000 and we thank the Congress for the increase of \$10 million over the President's request for FY 2016. That increase allows the OIG to increase our staff by 20 fulltime equivalents (FTEs) instead of a cut of 10 FTEs as the President's budget request would have necessitated. However, even with the increase in the FY 2016 budget, the OIG does not have the resources to allow for the needed oversight of VA's growing programs and operations. We view FY 2016 as the first step in right sizing the OIG's budget and staffing levels to an appropriate ratio given the size, scope, and complexity of VA's mission and organization.

BUDGET REQUEST FOR FISCAL YEAR 2017

We appreciate the recognition by the President that the OIG's budget needed to continue to grow in FY 2017 and would like to acknowledge the support that the Secretary gave during the budget formulation process. For FY 2017, the President requested and we hope the Congress will approve \$160,106,000. This will enable the OIG to staff up to 790 FTEs.

This budget request will begin to increase our oversight of critical VA programs and services. It will support deployment of additional positions including healthcare and

benefits inspectors, criminal and administrative investigators, auditors, and other support staff at both new and existing locations nationwide, especially areas of the country where there is no permanent OIG presence and has a growing veteran population. This funding will support increased oversight activities related to mental health care, patient safety, facility inspections, major and minor construction projects, Choice Act programs, transformational initiatives related to claims processing, emergent criminal activity and threats to physical and information security, along with providing increased oversight for the expansion of VA programs in general.

Veterans Benefits Administration

Our goal each fiscal year is to issue inspection reports for 20 VA Regional Offices (VAROs) as part of our cyclical benefits inspection program. However in FY 2016, that number will drop to 10 due to reviews associated with several of the over 40 initiatives that VBA rolled out as part of its transformation plan. Two initiatives that we will review in FY 2016 and continue our oversight into FY 2017 are related to centralized mail processing and the national work queue—the system VBA will rely upon to track and manage its workload moving forward. An expansion of the OIG budget provides for more benefits inspectors to return to a 3-year oversight plan of performing 20 inspections of VAROs per year but also enable special reviews to be planned in order to examine the effectiveness of VBA's mission-critical processes and support systems.

We remain concerned about the accuracy of VBA's continued reporting on reducing the backlog and improvement in accuracy. In FY 2015, we conducted 13 reviews at 11 VAROs on allegations of data manipulation.² We are also concerned that due to the focus on rating claims processing, there is a growing workload associated with non-rating claims as well as an increase in workload in the appeals area.³ Additional oversight is needed in these areas.

In June 2014, we issued a report in which we substantiated allegations that the Oakland VARO had not processed or properly stored information claims for benefits.⁴ Based on requests from several Members of Congress, we conducted another review in 2015, specifically focusing on an allegation that VARO management had a list of over 13,000 unprocessed informal claims for benefits. In January 2016, we reported that we could not find evidence of the existence of a list even after interviews with current and former VARO staff, whistleblowers, and members of a previous VBA management team.⁵ We did obtain a list of 1,308 informal claims that contained veterans' names and file numbers, and appeared to represent a working list compiled during the time of the special informal claim review project in 2013. Both VBA and the OIG examined this

² VA Regional Offices: Baltimore, MD; Boston, MA; Denver, CO; Honolulu, HI; Houston, TX*; Little Rock, AR; Los Angeles, CA*; New York, NY; Oakland, CA; San Diego, CA; St. Paul, MN (*denotes two separate reviews).

³ In the Benefit Inspections reports for FY 2015, we have consistently reported our concerns related to the lack of focus on non-rating claims.

⁴ *Review of Alleged Mismanagement of Informal Claims Processing at VA Regional Office Oakland, California*, February 18, 2015.

⁵ *Follow-Up Review on Mismanagement of Informal Claims Processing at VARO Oakland, California*, January 8, 2016.

information to ensure veterans claim information was accountable to the extent physical evidence existed. We did find errors in effective dates as well as the VARO having significant delays in processing claims. VBA took timely action to address our concerns and also reviewed 100 percent of approximately 1,300 informal claims.

Veterans Health Administration

The Veterans Health Administration (VHA) is under considerable stress to provide timely and quality care for veterans both inside VA and outside of VA. An increase in the OIG's budget provides for increased oversight of the risks that VHA faces in implementing the Choice Act including risks associated with the delivery of care and the payment of that care. This is especially important for veterans in rural settings as they face unique challenges to obtain care then those veterans living in more urban areas.

These risks are evident in the OIG's reports on urology issues at the Phoenix VA Health Care System.⁶ The system was overwhelmed with requests for outside appointments due to a lack of VA staff. Problems occurred with referrals, outside appointments being scheduled, veterans knowing and keeping the appointments, bills being paid, and most importantly, the outside medical information being inputted into the veteran's medical record. This was just one clinic in one facility. The enormous task ahead of VHA needs and requires OIG oversight to ensure that processes are in place to protect not only the veteran's health but also their tax dollars.

Recent OIG reports have identified issues related to the various call centers operated by VA, including the Veterans Crisis Line (VCL).⁷ In a report issued earlier this month, we substantiated allegations that:

- Some calls routed to backup crisis centers were answered by voicemail.
- Callers did not always receive immediate assistance from VCL and/or backup center staff.
- VCL management did not provide social service assistants with adequate orientation and ongoing training.

We identified gaps in the VCL quality assurance process including an insufficient number of required staff supervision reviews, inconsistent tracking and resolution of VCL quality assurance issues, and a lack of collection and analysis of backup center data.

In December 2014, we reported on issues related to the National Call Center for Homeless Veterans.⁸ In that audit, we identified 40,500 missed opportunities when the

⁶ *Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ*, January 28, 2015; and *Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ*, October 15, 2015.

⁷ *Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns*, Canandaigua, New York, February 11, 2016.

⁸ *Audit of VHA's National Call Center for Homeless Veterans* December 3, 2014.

Call Center either did not refer the homeless veterans' calls to medical facilities or it closed referrals without ensuring homeless veterans had received needed services. We also found problems for homeless veterans with leaving messages on answering machines when counselors were unavailable, referrals that could not be made due to problems with the messages, and a lack of documentation that veterans had received needed support services.

VA manages a number of call centers, and these centers face some unique and similar challenges. For example, during our work at the Philadelphia VARO, we found unacceptable working conditions and received feedback from staff that their performance standards did not provide sufficient time to enter notes and review emails. We are pleased to note that the problem with the site conditions has been addressed and the call centers have been relocated into the main building housing the Philadelphia VARO employees.

As was mentioned earlier, the OIG continues to receive requests from Members of Congress regarding the operations of VA facilities that serve their district and states. Often these requests require reviews of multiple clinical areas and address a broad range of quality of care issues. These reviews are resource intensive both with staff and time. For example in the last two weeks, we have been requested to review three VA Medical Centers. An increase in FY 2017 to better manage the increased volume of health care related requests, would allow for the expansion of staff within the Office of Healthcare Inspections.

Other VA Programs and Operations

VA has many other challenges in the programs and operations outside of VBA and VHA: construction, information technology (IT) and security, and contracting for vital goods and services. Each of these areas need vigorous oversight to ensure that taxpayer money is spent correctly and appropriately.

The issues related to the replacement facility in Denver need to be addressed. We are completing work on a review and plan to issue a final report in early Spring. This work is examining issues specific to the site conditions and taking a broader look at how VA manages its construction projects. It will be important, that as VA moves forward, we increase our oversight of both major and minor construction projects especially because VA has an increasing number of older facilities and decisions need to be made on how to spend construction money in an effective and efficient manner.

IT related issues have long been reported by the OIG as a challenge. VA has struggled with the planning, deployment, and security of systems. As was noted in the FY 2015 Consolidated Financial Statements audit, information security was once again rated as a material weakness.⁹ VA continues to rely on legacy systems for mission critical items. Our work with regards to the contract for development of the Veteran Benefits Management System (VBMS) further demonstrates VA's difficulties in planning for new

⁹ *Audit of VA's Financial Statements for Fiscal Years 2015 and 2014*, November 16, 2015. IT security has been a material weakness for over 10 years.

IT systems.¹⁰ In this report, we focused on whether VA had improved its schedule, cost, and performance supporting VBMS development to meet its claims processing accuracy and backlog elimination goals. We noted that VA remained partially effective in managing VBMS development to help meet claims processing accuracy and backlog elimination goals. We also found that VA stayed on schedule in deploying planned VBMS functionality to all VAROs in 2013. However, since September 2009, total estimated VBMS costs increased significantly from about \$579.2 million to approximately \$1.3 billion in January 2015. The increases were due to inadequate cost control, unplanned changes in system and business requirements, and inefficient contracting practices.

VA operations require the efficient procurement of a broad spectrum of services, supplies, and equipment at national and local levels. OIG audits and reviews of support service contracts, Patient Centered-Community contracts, and allegations regarding other contracts identified systemic deficiencies in all phases of the procurement process including planning, solicitation, negotiation, award, and administration. The OIG attributes these deficiencies to inadequate planning, oversight and accountability.

Recurring systemic deficiencies in the procurement process, including the failure to comply with the Federal Acquisition Regulation and VA Acquisition Regulation, and the lack of effective oversight increase the risk that VA may award contracts that are not in its best interest. Further, VA risks paying more than fair and reasonable prices for supplies and services and making overpayments to contractors. VA must improve its acquisition processes and oversight to ensure the efficient use of VA funds and compliance with applicable acquisition laws, rules, regulations, and policies.

The OIG continues to be successful in its criminal investigations of businesses that receive contracts for work under false pretense under the Service-Disabled Veteran-Owned Small Business program. Our oversight helps to ensure the right firms and eligible veterans receive this work. In June 2015, a former VA employee who worked as a supervisory engineer at the East Orange, New Jersey, medical campus of the VA New Jersey Health Care System was sentenced to 46 months in prison for accepting more than \$1.2 million in kickback payments in connection with VA contracts awarded to companies with which he had relationships, and to engaging in a scheme to defraud the VA by claiming one of those companies was owned by a service-disabled veteran when it was not. As a supervisory engineer, the former employee had the authority and influence to direct certain VA construction contracts to particular companies. He partnered with another individual, who was not a veteran, to set up three companies that could be used to obtain VA work under set-aside SDVOSB contracts. He then directed more than \$6 million worth of VA construction projects to those companies. The defendant admitted he accepted \$1,277,205 in kickbacks in exchange for his official action and influence between 2007 and July 2012. He also admitted that for many of the projects awarded to the other individual's companies, he recruited other contractors to perform the work so the companies were able to keep the money paid to them without having to incur the expense of actually completing the projects.

¹⁰ *Follow-up Review of the Veterans Benefits Management System*, September 14, 2015.

OIG's Office of Investigations

The OIG's Office of Investigations reaches into all areas of VA consistent with our mission to detect and stop fraud, waste, and abuse. After the allegations wait time manipulations surfaced, we devoted a significant amount of resources to reviewing these allegations.

As we stated in other testimony to Congress, the OIG has completed 77 investigations and provided the results to the VA's Office of Accountability Review (OAR) for appropriate action. We are working diligently on the remaining investigations. We are preparing a final report that will be issued for each facility that we investigated, but we must ensure we fulfill our responsibility to comply with applicable statutes governing the release of information, including an individual's right to privacy and the protection of veterans, whistleblowers, witnesses, and other sources that may be identified in the information transferred to OAR. This is an extensive, meticulous, and time-consuming process.

The OIG's Office of Investigations has been leading on the issue of allegations of wait time manipulation with assists from other OIG offices as needed. However, based on lessons we have learned through the completed 77 investigations, going forward, we will do more triaging of the allegations and determine which OIG office would be better situated to review allegations related to wait time manipulation.

With the proposed increase in FY 2017, we would increase the number of investigators to address criminal and inappropriate administrative activity related to procurement, fiduciary issues, workers compensation, drug diversion, and identity theft.

CONCLUSION

The OIG needs to have the appropriate level of funding to provide for the necessary oversight of VA programs and operations that the Congress, VA, and most importantly, the veteran expect. Congress began that process in FY 2016 and the request for FY 2017 continues this effort. We continue to base our work on those areas in VA with the highest risk either to patient care, employee safety, or other financial and contractual risks.

We are currently waiting and excited for the Senate to confirm the nominee to be the Inspector General. It is my privilege to serve as the Deputy Inspector General and the last 8 months have been filled with many professional challenges for me and the organization. However, on behalf of the OIG staff, I can say we are committed to the OIG mission of providing independent oversight of the programs and operations of the VA. When the nominee is confirmed, the staff and I are committed to assisting him as he leads and shapes the organization in dedicating resources to provide oversight to improve VA operations and programs to better serve veterans.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or members of the Subcommittee may have.

Senior Executive Biography

John David Daigh, Jr., M.D.
Assistant Inspector General for Healthcare Inspections

John Daigh, M.D. joined the VA as the Associate Director of Medical Consultation in the Office of the Inspector General (OIG) in January 2002 and was appointed as the Assistant Inspector General for Healthcare Inspections in January 2004. In this position, he is responsible for the OIG initiatives that review the quality of health care provided to veterans in VA hospitals, clinics, and nursing homes, in addition to the care provided to veterans through various health care contracts. He provides consultation to the investigation and audit sections of the OIG.

Prior to joining the OIG, he was on active duty with the U.S. Army for 27 years, retiring as a colonel in 2001. Dr. Daigh split his military medical assignments between Walter Reed Army Medical Center in Washington, D.C., and Fitzsimons Army Medical Center in Denver, Colorado. His last medical assignment was as the Chief of Neurology at Walter Reed Army Medical Center where he supervised the delivery of medical care by the Department of Neurology, and the academic programs and training experiences of physicians and medical students who were training in neurology. Dr. Daigh is Board Certified in Child Neurology and Pediatrics. He obtained his medical degree from the University of Texas, Southwestern Medical School, in Dallas, Texas, upon graduation from the United States Military Academy (class of 1974). He trained in Pediatrics and Neurology in Dallas, Texas, and Denver, Colorado. Dr. Daigh is licensed to practice medicine in Maryland.

Dr. Daigh is a Certified Public Accountant who obtained his undergraduate accounting education at the University of Maryland, University College. He studied taxation at American University in Washington, D.C., where he earned his Masters in Taxation. He is licensed as an accountant in Maryland. His last assignment while on active military duty was as the Director of Program, Budget, and Execution for the TRICARE Management Activity, the appropriation holder for the military medical appropriation. In this position, he led the effort by the military medical services' resource managers to properly budget and administer the military health care appropriation.

Dr. Daigh was born in Ft. Worth, Texas, to a new lieutenant in the Army. His childhood was spent at various locations as his family moved to comply with the request of the Army. He graduated from high school in Highland Falls, New York. Dr. Daigh is married and has two children. He and his wife reside in Maryland.

RELEASE OF IG REPORTS

Mr. DENT. Thank you, Mrs. Halliday, for your testimony.

I will start off by asking this: Last week your office released a report describing problems with the VA veterans crisis hotline—calls going to voicemail, et cetera. The data from the report was from December 2014.

In response, the VA made major changes to the management of the hotline, yet your report was not made public until 15 months after your investigation and it did not describe responses the VA had made in the interim.

I certainly don't want to be an apologist for the VA, but it seems there is such a time lag in your reporting that your recommendations might be outdated. The report no longer fulfills its intended oversight purpose and misleads members of the extent of the problem.

What are you doing to try to speed the release of reports in order to increase their relevance?

Mrs. HALLIDAY. OK. I will answer first, then I will ask Dr. Daigh to weigh in.

The scope of the review covered fiscal year 2014 activity and the first quarter of fiscal year 2015 to look at current information. It takes a while to collect all the information and get reports written.

I would contend some of the conditions are still occurring. VA's implementation plan for corrective actions spans target milestones of April 1, 2016 through September, I believe—it could be December. These are current issues impacting the call centers.

And I will ask David if he would like to add anything.

Dr. DAIGH. I think in speaking directly to the issue of the timeliness of our reporting, I think first of all we are well aware of that issue and we have worked hard to try to resolve it. But there are a couple of things that have happened that I think it is important for you to understand.

I had the capacity historically to publish about one hotline a week, somewhere between 50 and 60 reports per year. That would be a report where we go out onsite, do an intensive review, and come back and write a document supporting the elements, and then publish it.

I am now getting about 50 hotline allegations a week. So that would mean out of the 38,000–39,000 contacts, my office sees 50 complaints a week—50. So that means that I can actually select one out of 50 hotlines and expect to get it published.

The way we do our work is that I currently employ two psychiatrists and a number of social workers and other folks who have spent time in mental health, and we would consider this a mental health issue. So when we get a project we assign a team that is put together of members across the country best fit to look at the issue. And, frankly, I have people assigned to too many projects.

So in my desire to meet the requests I get from you and to try to timely address what we think are critical issues coming in, I have probably got people assigned too much work to complete it quickly.

We have plans and we are striving to get these reports out more quickly. I think when the new I.G. comes onboard, if he is con-

firmed, then we can sit down and talk about other issues and changes we can make to try to streamline the process. But I think additional people will help me decrease the burden for each individual working for me, and I will then be able to increase the timeliness of the reports.

REFUSAL TO RELEASE IG REPORTS

Mr. DENT. Thank you.

And on a related note, in an article in yesterday's USA Today they reported that despite repeated requests from members of Congress and the press, that your office has refused to release 71 reports that you completed documenting appointment scheduling problems throughout the VA system. Without the release to the public, no one really knows how severe the problem is or where the problem health centers are.

What is your justification for keeping these reports secret?

Mrs. HALLIDAY. It has always been my intention to publish our reviews of wait times. The wait time review started as a criminal investigation and many of them turned out to be administrative matters when we determined there was no criminal activity—so those reports are different than what normally comes through our pipeline.

We first decided to issue all of the information on our wait times investigations as a compendium, and then we looked at the compendium and it just did not provide enough information to the public. It begged more questions than it answered.

We went back and we came up with a way to make sure that the public would get good information that told the story of the extent of the work we completed on these cases. This process involves a lot of work.

All of these reports had protected personal information that we could not release under privacy acts and other statutes, such as patient information, names of confidential informants, names of whistleblowers, and such. The reports had to be de-identified.

We started a process to get that done. It is timely when you are dealing with the volume of reports we are, and the decision was to push them out by state so that the Congress would have all the information affecting their districts at once so they weren't getting information piecemeal.

I expect the reports to start going out some time next week. There are a ton of them. Now, there are 77 that are completed and there are still some other investigations in progress where we might not have tidied up loose ends.

Mr. DENT. You will release the 77 then?

Mrs. HALLIDAY. We are working on it, yes. They will not all go out next week, but they will go out by state, and there is a large group of them. There are a team of people in the OIG working on this priority in addition to conducting their regular work, to make sure this happens.

Mr. DENT. How many do you think you will release next week?

Mrs. HALLIDAY. I was hopeful to publish two of the bigger states where we had more cases. Could be anywhere between 15 to 20.

Mr. DENT. OK.

Mrs. HALLIDAY. They are going to go out on a regular basis. We just have a small infrastructure in our I.G. for all of these pieces and we are pushing them through at the expense of overtime in certain areas and bringing people in from the field to help do this.

It was never my intention not to be transparent on this.

Mr. DENT. Thank you.

At this time I would like to recognize Mr. Bishop for his questions.

Mr. BISHOP. Thank you very much.

THIRD-PARTY BILLINGS

I want to start my questioning with third-party billings. Third-party billings continue to increase, but the difference between billings and collections is also increasing.

In fiscal year 2007 the difference between the billings and collections was a little over \$2 billion. In fiscal year 2014 the difference was almost \$4 billion.

All of the collections go on to the Medical Care Collection Fund and they are used for veterans' health care programs. In fiscal year 2016, VA anticipates third-party collections of \$2.5 billion. In fiscal year 2017 it hopes for \$2.66 billion in collections from third parties.

Well, you issued your last report on VHA billings and collections problems in 2012. Are you conducting another study of this? And if so, when will that be released? If not, why not?

How has the VA responded to your previous findings and recommendations in this regard? Have you heard from the VA's CFO, as opposed to the chief business officer of the VHA, on your reports? And I think that the CFO would be just as interested in money that is due to the VA as he would be in paying the bills that are submitted by outside health providers under the Choice Act.

So if you could address that briefly I would appreciate it.

Mrs. HALLIDAY. Medical care billings and collections are very important to VA's efficacy of their budget. We are doing work. It is starting this next month and it is going to probably end up with a report in 2017.

We were giving VA time because it did a consolidation of its billing and collections into, I believe it consolidated into seven hubs, and we wanted to make sure that any inefficiencies we identified in the process were not attributed to a learning curve. Now that there has been sufficient time, we are going to bring in auditors to examine these processes, and I think it is a good time to do the review and to follow up on our prior recommendations.

The other piece of this is the ICD-10, which is a conversion to an all new coding system that was also impacting billing and collection information, and it really was a good decision to stagger the work.

IMPACT OF INCREASED BUDGET REQUEST

Mr. BISHOP. OK. Thank you for that update, and we are looking forward to that.

According to your fiscal year 2017 budget documents, your request represents the first of what VA believes will be a sustained series of appropriation increase requests in order to right-size the

OIG staffing levels. And you, of course, referenced that in your opening statement.

Is there a plan associated with the increase that you could share with the committee? And what would the I.G. be able to do with the additional resources?

I find it interesting that you are finally seeing higher funding levels because your operations actually provide a tremendous return on investment. I think it is \$22 in monetary benefits for each \$1 of OIG resources that are expended, including recoveries that are returned to the government of \$3 for every \$1 of your resources.

So can you explain the different ways that the money is recovered, how it is reinvested back into VA, and is it safe to say that you will recover more with the higher funding level that you are requesting?

And then finally, how many findings do you have against VA currently, and do you have a resolution process and a timeline for the remedy?

Mrs. HALLIDAY. What I am proposing is a strategic and tactical way to increase our resources so that we integrate new staff in key areas where the workload is just too high for us to take all of the work that we want to take, that we believe merits review.

We thought over a 3-year period we would need approximately 1,160 staff. To integrate that many new staff, given the small organization that we are, and do it effectively, it is better to do it as planned growth and bring people in and get the processes in place to bring them onboard and bring them up to what we believe the quality standards need to be associated with the I.G.'s work. That is why we decided to go with a 3-year plan.

I can provide more details to the committee, and I will be glad to do that.

[The information follows:]

The expansion plan is a phased effort to “right size” OIG to a level commensurate with the scope and complexity of the VA mission. It includes growing the organization to 1,160 FTE over a three year period through incremental budgetary increases totaling \$97 million.¹ These staff resources, to include additional health care inspectors, auditors, criminal investigators, and hotline analysts and would be positioned at new and existing locations nationwide to better serve VA facilities and address demands associated with changing demographics and emergent issues. Critical mission focus areas include:

- Responding to the increased volume of Hotline complaints and reviewing more of these complaints internally (in lieu of VA referrals)
- Improving VHA patient care through increased numbers of inspections and reviews
- Establishing full time mental health teams with expertise in PTSD, homelessness, and substance use disorders
- Increasing the integrity of VA benefits and services—especially Patient Centered Care, construction, and Information technology—through addition audits and reviews
- Detecting and deterring criminal activity related to identity theft, procurement fraud, and drug diversion

Year 1 – Fiscal Year 2017

- Budget request of \$160 million (\$23 million increase above 2016 enacted)
- Supports hiring of approximately 100 new employees (total of 790 direct FTE)
 - Expansion of administrative investigations teams, benefits inspections teams, and contract review teams.
 - Increase legal support to address increase in Freedom of Information Act request and need for improved responsiveness.
- Staff to be allocated nationwide (currently OIG lacks a presence in 24 States)
- Establish 1 new location in the Southwestern United States

¹ Excludes construction requirements which are currently requested as a line item in the VA Major Construction budget

Year 2 – Fiscal Year 2018

- Budget request of \$197 million (\$37 million increase above 2017 request)
- Supports hiring of 185 new employees (total of 975 direct FTE)
 - Initiates right-sizing of OIG audits and evaluations teams, OIG criminal investigations teams, and health care inspections teams nationwide at existing locations.
- Establish at least another new location in the Southern United States

Year 3 – Fiscal Year 2019

- Budget request of \$234 million (\$37 million increase above 2018 request)
- Supports hiring of 185 new employees (total of 1160 direct FTE)
- Continue staff allocations nationwide to better serve VA facilities
- Establish another new location in the Southwestern United States

The second thing: In providing the details, if we have a new Inspector General he is going to have his views, too. I can lay out all of the areas where I believe we have serious needs that are not being addressed, but ultimately it will be the Inspector General's call.

Mrs. HALLIDAY. As far as VA's unimplemented recommendations, I have a periodic report that should be on my desk. I can present that, and I will give you all the details and all of the information associated with the recommendations we made and which ones are still outstanding.

[The information follows:]

The OIG has a division dedicated to conducting follow-up on recommendations for improvement made in OIG reports. The follow-up process commences 90 days after the publication date of an OIG report and continues on a quarterly basis until VA has provided evidence demonstrating they have sufficiently addressed each recommendation. When the OIG Follow-Up Division sends a status update request to VA, VA has typically 30 days to provide a response indicating what progress has been made in the preceding 90 days toward implementing the recommendation and to provide supporting documentation, if applicable. OIG subject matter experts review the response and determine whether the narrative update and documentation provided by VA are sufficient to close the recommendation. The OIG notifies VA of the results of this review, and the process repeats every 90 days until all recommendations in the report are closed by the OIG.

Recommendations that VA does not implement within 1 year of issuance are subject to additional reporting to Congress. The OIG's Semiannual Report to Congress lists all unimplemented recommendations that are greater than 1 year old as of the close of the second and fourth fiscal quarters (March 31 and September 30, respectively).¹ Additionally, we provide the House and Senate Veterans' Affairs Committees with a supplemental status report on unimplemented recommendations as of the close of the first and third fiscal quarters (December 31 and June 30, respectively).

During the hearing, the OIG offered to provide the committee with a copy of the most recent Periodic Status Report on Unimplemented OIG Recommendations for the reporting period ending December 31, 2015. The report will be provided to Subcommittee staff.

¹ See Appendix B beginning on page 103 of the OIG's most recent Semiannual Report to Congress for the reporting period ending September 30, 2015. <http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2015-2.pdf>. Accessed March 14, 2016.

Mr. BISHOP. Thank you very kindly. I appreciate the succinctness of your answers.

Mr. DENT. Thank you.

Let me go to Representative Roby. I recognize her at this time.

Mrs. ROBY. Thank you, Mr. Chairman.

And good morning, Mrs. Halliday and Dr. Daigh. Thank you for being here to answer our questions today.

PROBLEMS AT CENTRAL ALABAMA VA HEALTH SYSTEM

I am going to build off of the chairman's comments about the I.G. reports that have not yet been released, and I hope you came here in anticipation today for me to ask specifically about Central Alabama Veterans Health System. As you know, just some time ago the hospitals in Tuskegee and Montgomery, Alabama were the number one and number two worst hospitals in the country for wait times.

And, quite frankly, if we had waited on the I.G.'s report to expose all of the mismanagement and malfeasance that had taken place at CAVHCS, I am not really sure where we would be today. Thank God we had whistleblowers that were willing to step forward and share their stories.

I mean, we had thousands of unread x-rays, altered medical pulmonology medical records; and as you know, we even had a VA employee take a veteran to a crack house to purchase drugs and a prostitute all to exploit that veteran's health benefits.

So I am disgusted about—just like everybody up here—about what has happened all over this country. But I am particularly concerned that if it had not been for these whistleblowers, where our veterans' health at Central Alabama would be today.

Fortunately, we were able to build upon and shine the light on what happened in Montgomery and Tuskegee and throughout Central Alabama, but I just—I need for you to give the people that I represent, the veterans that I represent, assurance that you are going to give us some information so that we can continue to move forward on improving veterans' health in Alabama.

Mrs. HALLIDAY. You are definitely correct, and we depend on whistleblowers to give us good leads to go out to actually find many of the problems.

I am going to return this to Dave to answer because he has done the majority of the work at this facility.

Dr. DAIGH. Congresswoman Roby, I share your concern. We have met with your office several times talking about these issues in great depth, and we have relayed our findings to you as we have been able to do our work.

If I thought that change only occurred after we published a report then I, too, would share some of the concern you have about the delay. But I think in actuality we converse with VA on these issues in real-time basis, so they understand what we are finding; they understand what the issues are.

And when we write a report, at the back of the report they have a response to our recommendations. And they have often completed those recommendations by the time we get to publication.

So I am extremely concerned that it takes too long for us to get reports out. No lack of concern about that. But I believe that change begins as soon as we find serious issues.

For example, I got an e-mail today, this morning, alleging a problem at a hospital with the use of the Choice Act. It was a serious documentation so I picked up the phone, I called VHA senior people and laid out that there was a certain issue at a hospital that they needed to address right now.

And we will go through, you know, trying to protect the identity of whoever made the call and the data that I have, but VHA needs to act now and we need to then review that issue systematically to make sure we can bring data forward to decision-makers.

Mrs. ROBY. Are you prepared to testify today about your most recent findings at CAVHCS and what recommendations that you have made? I mean, this is an onion and every time we peel back a layer we find another problem. And so we went, you know, from the falsified wait times to learning about, you know, the medical records that have been altered, and the x-rays, and it is just one thing after another.

And, you know, now we understand that the outside providers' bills are not getting paid so the recruitment efforts to have a community health network in Alabama are, for obvious reasons, delayed because, I mean, you can't expect a physician or a hospital to put themselves out there to support a veterans' health network when they are just not getting their bills paid.

So what have you found recently that you can tell me that you have suggested to CAVHCS and it is being implemented?

Dr. DAIGH. Well, we have worked through a number of issues with respect to their CBOCs and the management at the CBOCs and the ability for patients to be seen at CBOCs. We have discussed with them issues about their emergency room, and access and use of their emergency room. We have also discussed other issues with respect to the use of Choice.

And I think to be more specific I will have to wait until the actual documents can be presented. But we don't hide data from VHA at all. We work with them so that they understand where we are coming from and can make change as soon as we are aware of it.

Mrs. ROBY. My time is expired and I hope I will get another opportunity to ask you some more questions, but I would really love to have a date certain of when the report related to CAVHCS is going to be released as soon as you can possibly give that to me.

Dr. DAIGH. I will give it to you in writing when I get back to the office.

[The information follows:]

On February 29, 2016, we began a systematic roll-out of 77 administrative summaries of our investigations by state. We believe this to be the most beneficial approach so that Members of Congress and the public can receive information on the status of VA facilities in geographic areas that are of interest to them. As of March 18, 2016, we have published 49 administrative summaries. One of the 77 administrative summaries concerns a VA medical facility in Alabama, specifically, the Tuscaloosa VA Medical Center in Tuscaloosa, Alabama, and it was published on March 17, 2016. We hope to conclude the process of publishing all 77 administrative summaries by the end of the month.

A recent media report lists 111 facilities flagged for additional review by the Veterans Health Administration's (VHA) Access Audits, which included VA medical facilities in Mobile, Montgomery, and Tuskegee, Alabama.⁴ We believe the article may have left readers with the false impression that the OIG conducted wait time investigations at each of these 111 facilities. This is not accurate information. While it is accurate that these 111 facilities were flagged by VHA's Access Audits for additional review, the OIG never committed to review all facilities flagged for additional work. We discussed with VA the criteria that the OIG would use for adding facilities from VHA's access audit lists to OIG's list of investigative sites. We have been in continuous contact on this matter with VHA, VA's Interdisciplinary Crisis Response Team, and VA's Office of Accountability Review since May 2014, and they are well aware of the sites OIG investigated and those sites where VHA is responsible for further review.

We do have one forthcoming OIG healthcare inspection report regarding the Central Alabama VA Health Care System in Montgomery, Alabama, which concerns allegations of manipulation of the mental health appointment scheduling system. This is a healthcare inspection that reviews the merit of non-criminal allegations related to quality of care, not an administrative summary of a criminal investigation. The report is drafted and undergoing the OIG's internal editing process. We expect to publish this report in the next few months.

⁴ Slack, D. List of 111 VA Facilities Flagged for Wait-Time Investigation. *USA Today*. February 24, 2016. <http://www.usatoday.com/story/news/politics/2016/02/24/111-va-medical-facilities-flagged-investigation/80809426/>. Accessed March 14, 2016.

Mrs. ROBY. Thank you.

I yield back. Thank you, Chairman.

Mr. DENT. Thank you, Mrs. Roby.

At this time I recognize gentlelady from California, Ms. Lee, for 5 minutes.

Ms. LEE. Thank you, Mr. Chairman. I want to thank you and our ranking member for this hearing, and thank our witnesses for being here.

And I, too, just want to say to Congressman Farr how much I am going to miss him. We have worked together for many, many years, since the California legislature, and he taught me a lot. The base, for example, in his district in Monterey, he is so involved in the conversion and reconversion of it and it was an amazing kind of effort he undertook.

So, Sam, I am going to miss you.

Yes. Wonderful leader in California, too, on so many issues.

I wanted to ask you about Oakland.

And, Mr. Chairman, I apologize. I have another hearing, so I would like to ask all my questions and if we don't have time to get answers could I get them in the—have them for the record, please?

OAKLAND REGIONAL OFFICE CLAIMS PROCESSING DELAYS

First of all, wanted to ask you about this report as it relates to Oakland. Of course, I represent Oakland and I have worked with, again, Congressman Farr, Congresswoman Speier and Thompson to address the really outrageous backlog in Oakland and the failure of the claims processing at our regional office.

And now we have a report that has recently come out and, unfortunately, it still shows some significant delay in processing the claims. And let me just quote from this report: "We also determined Oakland staff did not timely process 9 of the 60 claims, resulting in significant delays in benefit payments to veterans. The delays ranged from approximately 5 years, to 7 years and 8 months."

And so, you know, while it is only 9, still that shows that there is still a significant problem. The recommendations: provide training to staff on proper informal claims processing procedures, conducting a complete review of the additional list of 690 claims and maybe informal claims, and to conduct another review of the remaining 1,248 claims.

So I want to find out from you what is the followup to ensure that the Oakland regional office follows through and is held accountable.

DELAYS IN PROCESSING APPEALS

Secondly, in terms of the steady reduction in the backlog of claims, I am really concerned now that we are seeing, again, in my district office that claims are being processed—as they are being processed more expeditiously, the increase in appeals are really going very, very slow. And so we need to find out how to address this on the front end so that the appeals process moves more quickly.

WOMEN AND MINORITY-OWNED BUSINESS CONTRACTS

Next, in terms of I.T.-related expenditures, I think in terms of costs, the budget is increasing from \$579 million to approximately—has increased to approximately \$1.3 billion in January 2015. Now, I want to find out how much of these costs go to contractors and how much of them go to women-owned and minority-owned contractors, and if you have a breakdown of minority contracting and women-owned business contracting. Because this is an enormous amount of money that is being spent, and I would like to just see how that is being spent.

PTSD DISABILITY CLAIMS

Finally, just in terms of the mental health system, those veterans returning with PTSD, want to make sure that they are receiving timely and accurate care because we are seeing more and more of this and it is really becoming a major, major issue in many of our districts with our veterans.

Some of the claims actually are being denied; some—and they—the burden of proof is on the veterans. But I don't know if you were involved in investigating any of the claims that have been rejected with veterans who insist and we know that they are—they have PTSD, and yet they are not being treated properly.

Thank you.

Mr. DENT. At this time you had some questions you would like to enter into the record, and we will do so without objection, yes.

Ms. LEE. Yes. Any that don't get—the ones I just asked, Mr. Chairman, and if they don't—if we don't have time to get them answered on the record, just the ones I asked would be for the record.

[The information follows:]

On the Oakland backlog report, what is the follow-up process to ensure that the Oakland VARO follows through and is held accountable?

The OIG has a division dedicated to conducting follow-up on recommendations for improvement made in OIG reports. The follow-up process commences 90 days after the publication date of an OIG report and continues on a quarterly basis until VA has provided evidence demonstrating they have sufficiently addressed each recommendation. When the OIG Follow-Up Division sends a status update request to VA, VA has typically 30 days to provide a response indicating what progress has been made in the preceding 90 days toward implementing the recommendation and to

¹ See Appendix B beginning on page 103 of the OIG's most recent Semiannual Report to Congress for the reporting period ending September 30, 2015. <http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2015-2.pdf>. Accessed March 14, 2016.

provide supporting documentation, if applicable. OIG subject matter experts review the response and determine whether the narrative update and documentation provided by VA are sufficient to close the recommendation. The OIG notifies VA of the results of this review, and the process repeats every 90 days until all recommendations in the report are closed by the OIG.

Recommendations that VA does not implement within 1 year of issuance are subject to additional reporting to Congress. The OIG's Semiannual Report to Congress lists all unimplemented recommendations that are greater than 1 year old as of the close of the second and fourth fiscal quarters (March 31 and September 30, respectively).² Additionally, we provide the House and Senate Veterans' Affairs Committees with a supplemental status report on unimplemented recommendations as of the close of the first and third fiscal quarters (December 31 and June 30, respectively).

On February 18, 2015, the OIG issued a report titled, *Review of Alleged Mismanagement of Informal Claims Processing at VA Regional Office Oakland, California*. The OIG substantiated the allegation that Oakland staff had not processed or properly stored informal claims for benefits. The VARO Director concurred with our three recommendations, all of which were implemented by March 19, 2015. However, during an April 2015 House Committee on Veterans' Affairs hearing, the OIG received a request from Congressman Doug LaMalfa to conduct a follow up review at the Oakland VA Regional Office (VARO). This request was based on an allegation that management had a list of 13, 184 unprocessed informal claims for benefits. Additionally, Congresswoman Jackie Speier asked the OIG to determine whether VARO staff altered dates of claim.

We published the results of our findings in a second report, *Follow-Up Review on the Mismanagement of Informal Claims Processing at VA Regional Office Oakland, California*. The OIG did not find evidence of the existence of the alleged list of approximately 13, 184 informal claims even after interviews with current and former VARO staff, whistleblowers, and members of a previous VBA management support team. The OIG reviewed 60 of 1,308 informal claims and found VARO staff had incorrectly processed 6 claims. Five errors contained incorrect effective dates that resulted in approximately \$26,325 in improper payments. The OIG also determined

Oakland staff did not timely process 9 of the 60 claims resulting in significant delays in benefit payments to veterans. The delays ranged from approximately 5 years to 7 years and 8 months. Through information obtained from VARO staff, the OIG obtained an additional list of 690 claims. The OIG provided management with the list to determine whether staff had correctly processed these potential informal claims. VARO management did not provide the oversight needed to ensure timely and accurate processing of informal claims, to include the 1,308 identified in March 2015. As a result, veterans did not receive accurate or timely benefits payments.

² See Appendix B beginning on page 103 of the OIG's most recent Semiannual Report to Congress for the reporting period ending September 30, 2015. <http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2015-2.pdf>. Accessed March 14, 2016.

The OIG recommended the VARO Oakland Director provide training to staff on proper informal claims processing procedures, conduct a complete review of the additional list of 690 claims that may be informal claims, and conduct another review of the remaining 1,248 informal claims. The VARO Director concurred with OIG's recommendations. As of March 18, 2016, all three recommendations made in our report are considered open. We issued this report on January 8, 2016. Based on the process described above, we will send our first status update request to VA on/about April 8, 2016, and VA will have until approximately May 8, 2016, to submit their response to the OIG. This process will repeat every quarter until the VARO demonstrates it has implemented all three recommendations.

I am concerned that the claims appeal process is going very, very slow. How do we address this on the front end so that the appeals process moves more quickly?

The OIG has had longstanding concerns that VBA's focus on rating claims processing and backlog reduction has created a growing workload associated with non-rating claims as well as an increase in workload in the appeals area. We believe additional oversight is needed in these areas, and we identified the appeals management process as an area where OIG plans to conduct oversight in FY 2016. Specifically, we plan to look at the timeliness of VBA's appeals process. We anticipate issuing this report early in calendar year 2017. We will publish the results of our review when completed and we would be happy to offer you and/or your staff a briefing of our findings.

How much of VA's \$1.3 billion IT budget goes to contractors, specifically, women owned and minority-owned contractors, if you have a breakdown?

VA, specifically the Office of Information and Technology, would be in the best position to answer this question. The OIG does not have this information.

We are seeing an increase in the denial of veterans' compensation claims for PTSD. Has your office been involved in investigating any of the claims that have been rejected with veterans who insist and we know that they have PTSD, and yet they are not being treated properly?

Decisions on individual benefits claims are the responsibility of the Veterans Benefits Administration. The OIG is not involved in the determination of VA benefits for PTSD or any other medical condition. However, from 2009-2012, the OIG reviewed the accuracy of PTSD claims completed by VBA. Initially we found error rates of approximately 15 percent. On July 13, 2010, a change to 38 CFR 3.304(f) took effect that lessened the burden of proof on veterans for proving they were exposed to a stressful event. Since the change in regulation, our reviews showed the error rate dropped to approximately 5-6 percent. As a result, the OIG discontinued our review of PTSD claims.

Mr. DENT. Very good.

Ms. LEE. Thank you.

Mr. DENT. Thank you.

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

LEADERSHIP VACANCIES AT VA FACILITIES

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Good morning.

I am sure you are aware of the perception that the VA engages in a bad-boss merry-go-round. I would like you to address this, please.

Mrs. HALLIDAY. There has been a significant change in leadership at many of the VA facilities. There are high vacancy rates. They are trying to fill those with qualified people.

I am not going to weigh in on them putting somebody at a specific facility. That is their management decision to do that.

However, you live with that management decision and over time you know whether it is effective or it is not. And there are some problems with that. There are some questions about people being put in different positions.

It is not really our role to say that they should or should not go into those spots, but it is our role to look at their effectiveness over time. That is probably not the answer you want, but that is really the reality of it.

Mr. FORTENBERRY. Embedded in your answer is a suggestion that the analysis beyond the decision to place an administrator in a particular position, which is beyond the purview of your authorities, but the analysis of the consequences of this is showing deficiencies in terms of the quality of care being delivered. That is what you are saying, I think. Is that correct?

Mrs. HALLIDAY. Once the individual is put into place you measure their performance, you measure their results, and at that point you hold them accountable.

Mr. FORTENBERRY. So how many cases of this would not be an acceptable standard of the delivery of appropriate management, as measured by health outcomes for the particular VA hospitals that they have been transferred to? Do you have metrics on this?

Mrs. HALLIDAY. I do not have metrics on those.

Mr. FORTENBERRY. Should you? Because again, you think about the problems that the VA is plagued with and continues to be plagued with, and yet you have a rotating—seemingly a rotating system where you are moving persons who did not deliver, in terms of management, outcomes that we all want to see, and they are shifted into a new position. The reports—some of which are quite egregious in terms of expenditures and salary levels.

The overall trajectory of our efforts, I believe the secretary's efforts, are to make sure that we are resetting the VA to deliver the highest and best care we possibly can. And yet this continues to happen. So what is the underlying cause of this?

Mrs. HALLIDAY. I believe it is lack of good succession planning and having significant vacancies throughout the whole system to get enough ready candidates with exemplary records that can step in and produce results. It also goes to the development processes

within VA to develop their executives so they really can effectively manage.

Investments in those areas are critical, and I believe——

Mr. FORTENBERRY. Developing an executive corps, if you will? There is no dynamic within the VA that does that.

Mrs. HALLIDAY. There are some. There needs to be far more. And I know VA has put a program for leaders growing leaders in place, and they are trying to season leaders.

I even struggle with that. Some of my team is new to the organization and you have to grow them. You have got to get them seasoned to deal with the challenges that come that are unpredictable.

Mr. FORTENBERRY. Does this also have anything to do with personnel law that inhibits the ability of the VA to fire people?

Mrs. HALLIDAY. No. But I do think that people should get due process on this.

My concern is something, and unfortunately Mrs. Roby left, but when you get an——

Mr. FORTENBERRY. That is one of the cases——

Mrs. HALLIDAY. Yes.

Mr. FORTENBERRY [continuing]. As you are quite aware. I think it is the same hospital that she keeps referring to. The administrator is moved to somewhere else, and large salaries and all this, and clearly there is not—the outcomes there did not meet a standard of care that we want to see, and yet there seems to be no consequence.

Mrs. HALLIDAY. My understanding is there has been a change in leadership there. That leadership has to have at least a certain period of time to make these changes and to realize the improvements.

VA OVERSEAS FACILITIES

Mr. FORTENBERRY. Let me quickly move to two other questions. How many VA facilities are overseas that are underutilized?

Dr. DAIGH. I am aware of only a couple of clinics that are overseas. And as to whether they are underutilized, I don't know the answer.

There is one in Manila and there is also a CBOC, I believe, on one of the Pacific Islands. We don't have very much overseas—the VA doesn't.

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Mr. DENT. Thank you, Mr. Fortenberry.

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

Mr. FARR. Thank you very much, Mr. Chairman, and thank you for your kind words. I was thinking as you were all—time is 52 years ago this month that I began my public service in the Peace Corps, and I have been in elected office in varied local, state, and federal levels continuously for 42 years, and I have learned a few things. I find in my old age I am beginning to think like a Republican on fiscal matters but still have a heart of a Democrat on delivery of services.

Mr. DENT. We have some extra seats over here if you want. [Laughter.]

Mr. FARR. No, because I—that heart part sometimes doesn’t come across——

Mr. DENT. By the way, you did a very good job on the Peace Corps funding this year. Just want to thank you for that.

Mr. FARR. No, so thank you for your help.

You have a really enviable job. One of my first jobs in government was working for the budget analyst in California, which Mr. Valadao knows is a really unique job because not only does the budget analyst analyze the governor’s budget, but it also can make suggestions very broad, outside the, you know, just inside the lines. And I think you have sort of ability to do that, too.

My frustration is that I have seen—the VA is just this incredible empire, but it is an empire within its own world. And the problem we have is that we are trying to keep everything within the lines then the veteran has now left—coming into VA has left a family where he lived in a real empire, a military base that had everything there. And now they are going to cope in the real world, and you just don’t turn around and those services are right there. Well, you don’t know how to get them.

And where I think the VA needs to go, and I would hope that your office would look at it, is that we have got to engage the rest of the village. This drug treatment that is going on in the VA—and I just talked to a judge who has set up veterans’ courts and he says he never puts a veteran in jail no matter how seriously heinous the crime, puts them all into rehab programs, but none of them with the VA because the VA rehab programs are such a failure because they are all old models, and that they have—really the community models—and this here is Santa Clara County, which is where the Silicon Valley is, has incredibly good social services at the local level.

He loves the vets. But he says that we really need to start paying attention to sort of outside the lines of veterans if we are going to—and the questions I have really go to that because it is—and I hope that you will—I think you have the authority to sort of color outside the lines of saying—see, I think where we fail in the Federal Government, all of us regardless of party, we don’t require any skin in the game from the communities and the states that benefit this.

California gets \$11 billion from the Department of Veterans Affairs—running veterans’ hospitals, veterans’ benefits. Those benefits go in to support our community college system, our state colleges and universities. It is one-tenth of the entire California budget, a \$100 billion budget. And yet they give a short shift to veterans: “Oh, that is a federal program.”

The problem is we in government have to stop thinking that the lines are just within our own jurisdiction. It is a federal problem; it is a state problem; it is a local problem.

It is all of us. And a frustration I have is now we have people running for president who are getting very popular by just bashing government.

And guess what? Some of those people that are joining that bashing are veterans, and they have the best services in America. And we have got to figure out how to deliver these services.

CHOICE ACT

So here are a couple of my questions about working with the local community. One is in the Choice Act, where you can go outside a veterans' hospital and go to the local hospital. The problem is the VA doesn't pay the hospital. The veteran has to put money out of pocket in an emergency room hoping that it will get reimbursed.

That is not the law; it is just the bureaucracy that won't do it. And I hope you—we could do it.

ACCREDITATION OF FAMILY THERAPISTS

The other is that we have this cockamamie problem in VA. We need with PTSD managed—we need family therapists, people that are trained to that. The VA only allows therapists that have been trained in a—in one accredited column, a national accreditation program.

None of the schools that are all in California are—use that, so not anybody coming out of the medical schools, coming out of the—of Berkeley, Stanford—they can't qualify to work for the VA in a community. They can go work for the VA because they will get separately trained, but they can't work in the community as a civilian therapist because of our requirement that you have to have this certain license or certain accreditation to be taught that.

So I want to know what the VA is doing about opening up hiring positions that are unnecessarily limiting the assessment of eligible applicants, and also how the VA can deal with the Choice Act and getting the reimbursement to nonveteran caregivers.

And I hope that in the future you will also tell us of the communities that are working well with the VA, or VA working well with them, and those that aren't, because we ought to not be just giving away all this benefit without requiring some skin in the game from the local community.

Mrs. HALLIDAY. Go ahead.

Dr. DAIGH. Mr. Farr, I have been here a little while and I appreciate your contributions also. It has been a joy to see you on the committee and hear your comments.

Speaking about outside the lines, I do have the opportunity to talk to the Under Secretary for Health and make suggestions directly to him about what ought to be done or what ought not to be done. And I can say to you that we currently have some efforts with respect to substance use disorder which I hope will bear fruit, where we have been able to bring serious, smart people outside of government who have some program expertise hopefully to work with VA mental health to adopt a nationwide standard to go forward.

We are working hard to get VA to reform their stroke protocols, for example, which I think are not up to speed, given what the best hospitals in many communities have.

So we in my office work with leaders in VA trying to move in what we think the right direction is. And sometimes we are successful, and sometimes we are not successful.

Mr. FARR. Do your reports indicate which of those are stubborn or not working? I mean, that is where I think Congress can—we can nudge.

Dr. DAIGH. I understand that, and I would say that I have very frank conversations with your staffers in general when there is an issue that comes up and I feel like we are not making the progress that we need to make.

And so I believe that we do try very hard, both through official means and through unofficial means, to get the ball moved in the right direction.

To write an official report I need a certain amount of documentation, et cetera. But like I described this morning, I can pick up the phone and call anyone I need to. They will talk to me quickly, and we can usually get things moving.

Bigger-ball issues, you know, are harder for me to get an Under Secretary to do something about unless I have data that suggests that it is the right thing to do. At least that has historically been the issue I have had with getting them to make a major course correction.

When they choose to make a major course correction it is just a big ship, and so it takes them a while to get that to happen. And I share your frustration with that but I have, over time, seen, I think, some reasonable accommodation and change.

The Choice Act has, in my view, highlighted the back-office problems that VA has in running a business. For example, we have a report out where a particular hospital had the occurrence of a loss of several providers out of a group of four or five. They need to rely on the community, and then when they go to the business office and say, "Hey, I need you to buy care in the community through Choice or one of the other programs they have," it just falls apart completely.

So I think in the last number of years the failure to attend to the consult system, making sure the data in the consult system is accurate—we have a large project right now where we are looking at one hospital at the consults that go in. Care could be provided in house or out house. We are tracing those consults out to the community and talking to the community docs to find out what happened, why it didn't work. Sometimes they didn't get paid for some months so they won't be seen.

So that report will come out. We are working through that.

So my plea is that when I talk about one hospital and say it has a problem, senior managers often say, "Well, it is an intermediate manager's problem," or, "It is a local manager's problem." And I have difficulty getting people to generalize and say, "Out of the 150 hospitals I have out there this is a significant problem."

So I almost always have to do a nationwide look to provide data to get them to say, "OK, that is the direction I need to go."

Mr. DENT. Let me at this time recognize Mr. Jolly, for 5 minutes.

SUFFICIENCY OF BUDGET REQUEST

Mr. JOLLY. Thank you, Mr. Chairman.

Thank you all for being here.

Just one quick question, and then I want to follow up on something Mr. Farr alluded to. I know last year there was some concern

about the President's budget for the I.G. office, but it appears this year the I.G.'s office is satisfied with where the President's number is or believes that is sufficient?

Mrs. HALLIDAY. It is, based on us implementing a 3-year plan for growth.

Mr. JOLLY. OK.

Mrs. HALLIDAY. We did process an appeal. The department supported that appeal and the monies went into the President's budget. Without it, at some point it would be a crippling effect on our organization to be responsive to all of you.

PROMPT PAYMENT TO OUTSIDE PROVIDERS

Mr. JOLLY. OK. Thank you.

What I want to follow up on—Mr. Farr just briefly alluded to it—is prompt payment to outside providers, and to get your assessment to the extent you have looked at this issue or if it is a candidate for an issue you might look at.

I continue to hear from outside providers who are simply not getting paid or not getting paid in a timely manner. And our own state hospital association, they conducted their own survey of their participating providers, and what they came out with—and this is very recent; this is December 2015 they put together a survey, the Florida Hospital Association—revealed that 95 percent of providers in the state of Florida had unpaid claims; 30,000 total unpaid claims totaling \$134 million in receipts; 10,000 of those claims were over a year old and 6,000 of those claims were over 2 years old; and 60 percent of the providers reported one or more incidents of dealing with the VA where the VA's response was that the claim had been lost.

That is on the large hospital institutional provider, but I also hear from, you know, single-sector providers, if you will—eye care, dermatology, whatever the specialty might be that gets referred out—where the smaller practice it does have a direct impact and it has a direct impact whether or not they can continue to serve the veteran population that they want to serve that is currently being underserved by the VA, as the nature of the outsourcing.

And I apologize if you have done studies on this, and I have missed them, but have you looked at this, or is this a candidate for something you might be looking at?

Mrs. HALLIDAY. We did extensive work looking at the PC3 contract initiatives, looking at the network adequacy, whether medical documentation was coming back into the records, whether bills were being paid timely. And then the new monies of Choice came in.

Mr. JOLLY. Right.

Mrs. HALLIDAY. We are looking at the Choice expenditures now. We are looking at not only what is being expended, what is sitting in a payable account and not being expended, because that is the feedback we are getting that it is more of a systemic problem. I don't have all the evidence yet.

We do have a requirement to audit the Choice expenditures and provide a report when 75 percent of the expenditures are complete. I think waiting that long doesn't allow time for corrective action, and we have initiated work in this area early to look at the expend-

itures within the fiscal quarters to find out whether we are seeing improvement or conditions are worsening. But there are two factors: one, an expenditure is what is paid, and two, there is a bigger problem with what is not being paid timely.

So there is a lot of work going on in our office.

Mr. JOLLY. And on delay of care, particularly in cases, you know, where you get to a year or 2 years, is—and I realize you may not have the hard data on this, and I might just be asking for supposition, but is it simply because of the amount of—is it the volume of claims or are claims having to go through secondary and third review and fourth reviews, or is it just mismanagement in many cases?

Mrs. HALLIDAY. At this point I don't have enough evidence to weigh in, but what we believe has happened is most of all of the processing is going to the Non-VA care program fee clerks at the medical center. It makes no difference whether they are processing a PC3 claim—

Mr. JOLLY. Right.

Mrs. HALLIDAY [continuing]. Or whether they are doing a Choice claim. So everything is concentrated there, and the process needs to be simplified.

Mr. JOLLY. OK.

Dr. DAIGH. Can I add a piece to that? In a couple of sites what we have seen is the business offices were not necessarily fully staffed. So you make a referral, "I would like to see a cardiologist." And if there is not one available in house you decide to outsource it. Then you have to process the paper.

The second problem we have seen is that some communities do not have the resources VA would like to see. So, for example, if you take a look at some of the early work in Phoenix, where the mental health demand was significant on VA's side, there really were not the providers in that community able to deal with the volume of cases VA had.

So I think it is a bit of a problem in terms of processing claims, but there is also a problem of are there providers there who, for what VA is willing to pay, will see people?

Mr. JOLLY. Right.

Dr. DAIGH. And so that gets jumbled together sometimes. And I am hoping that this one look will help us sort out where some of the problems are, but I think you have got to have a better preferred provider network in order to make it—

Mr. JOLLY. Sure.

Dr. DAIGH [continuing]. Go well.

Mr. JOLLY. But, you know, I would encourage you, though, to also consider for those who are providing we are beginning to push them away.

Dr. DAIGH. Right.

Mr. JOLLY. I mean, you can imagine the comments coming from the providers—particularly the smaller providers, particularly the one-or two-person physician shops that are still trying to deal with the new constraints of some of their reimbursements, period. They can't sit on a receivable for 6 months or a year or 2 years. And that will even make worse the situation you just described, which is available physicians in the area willing to see these veterans.

Dr. DAIGH. The other issue is that—

Mr. DENT. Please quickly answer that question.

Dr. DAIGH. I am sorry. The other issue is the transfer of data. So you send a patient out to see a doctor in the community; they need to be able to electronically get their data back in the VA system so the people in the VA can see it. That is a difficult interface right now.

Mr. JOLLY. Well, as you look at it I would appreciate the opportunity to work with you. As I mentioned, the Florida Hospital Association has done a pretty extensive survey of providers in the state of Florida that would probably be valuable to you all.

So thank you very much. I appreciate it.

Mrs. HALLIDAY. Thank you.

Mr. JOLLY. Thank you, Mr. Chairman.

Mr. DENT. At this time I would like to recognize Mr. Joyce, for 5 minutes.

RISK OF CYBER ATTACKS

Mr. JOYCE. Thank you, Mr. Chairman.

Mrs. Halliday, I understand that the information technology—and Doctor Daigh was just talking about some of the information—security. The information security is part of the critical oversight that needs to be addressed.

You indicate that ongoing issues related to the planning, deployment, and security of the VA systems as well as the problems that antiquated systems or legacy systems that are there. Last few years obviously our nation has come under cyber attack. To your knowledge, what can you—how is the VA responding and are they responding strongly enough to the risk of a cyber attack in order to coordinate this and make sure that our veterans' records are—and their confidentiality being kept intact?

Mrs. HALLIDAY. The VA has put a process in place. It has a group controlling where they have violations and complaints that a veteran's information has been accessed.

But with information security, it is never enough. You have got to tighten down these systems, and it is very hard to tighten down a legacy system.

I think they do have controls. I think the reporting is in place to get on a threat quickly. But you always have some risk associated with threats to information security.

It is the last material weakness reported in our audit of the VA's consolidated financial statements. And they are working to try and close down all of the various threats, but new ones crop up every day. So it has to be a religious effort. Has to be aggressive, and you have got to have the right people to make sure that you have corrected the problems.

PROBLEMS WITH LEGACY COMPUTER SYSTEMS

Mr. JOYCE. Thank you for that. But as I have visited the different hospitals they would talk about the fact that this legacy system doesn't interface, such as intake with medical records and vice-versa. Do you think we would be better served by creating a system starting to go in effect for 2018 in disbanding the legacy system?

Mrs. HALLIDAY. The system definitely has problems with integration. To replace the system as quick as 2018 would be very difficult. I think VA and DOD—

Mr. JOYCE. I am sorry—

Mrs. HALLIDAY. In the future you are going to have to put a system in place. All the medical centers have modified their main system, Vista, and they run with different codes and they have problems. They are going to have to put a better system in place if they really want to track veterans, especially with the demand just continuing to increase.

Mr. JOYCE. I didn't mean to set 2018 as the set date.

Mrs. HALLIDAY. OK.

Mr. JOYCE. I am just saying some set date in the future, don't you think we would be better served? You mentioned that they are—everybody is putting bandaids on the legacy system. That doesn't work. I mean, we all operated in 1965 with a yellow box or a blue box and it—

Mrs. HALLIDAY. I think there are great risks in maintaining these legacy systems.

Mr. JOYCE. Right.

Mrs. HALLIDAY. We need to find a system that works. We have veterans that move because of the weather down to the warmer states. We have got to be able to transfer all this information and have it available quickly.

Some of these legacy systems are just tough to work with because they have been modified across the nation to serve the needs of the individual medical center.

Mr. JOYCE. Well, I think it is an absolute sin that—when I heard that when somebody shows up for the first time that they send them back to their—where they came from and that it is their duty to go get their records so they can input them in the system. Those are their records and they should follow them throughout the system when they are putting their lives on the line for our country.

CALL CENTER RELIABILITY

And so I think we need to be aggressive in how we pursue this going forward. And obviously security is a big issue.

I want to follow up on something that Chairman Dent had addressed at the beginning. You were talking about the call center. Has your office seen any improvement in the call center reliability as it relates to making sure that our homeless veterans receive the attention and benefits that should be afforded to them?

Mrs. HALLIDAY. Yes. I think when we made the recommendations on the call center and we dealt with making sure they had the right staffing to handle the calls coming in and the right procedures when they were at peak periods, there has been significant improvement there. There is also a better monitoring system in place to enable the supervisors and the management to monitor the staff taking these calls.

My big concern was that there was a tremendous number of veterans where after VA took the call, there was no assurance that the services the veterans needed at the medical center were actually provided. The call came in, it was documented, and then sent off to the medical center without additional tracking.

Now I believe they have connected the fact that there is a responsibility to make sure that the homeless veteran gets the services they need. And it was a particular challenge in the homeless call center because a lot of them don't have phones. To have a call-back number was a problem in the contacts.

So I think we produced a very good report that moved positive change forward. Is it perfect? Don't know. We will go back in in about a year, given the problems that Dr. Daigh has identified in the suicide call center. We have reviewed almost all the call centers in VA. They all have issues.

Mr. JOYCE. And I see my time is up, Mr. Chairman, but in a lot of instances these people don't have a year and they need to be dealt with immediately.

Thank you, Chairman Dent.

Mr. DENT. Thank you, Mr. Joyce.

At this time I would like to recognize Mr. Valadao, for 5 minutes.

Mr. VALADAO. Thank you, Mr. Chairman.

Mrs. Halliday, thank you for coming before the committee today, and Mr. Daigh.

OUTDATED SCHEDULING SYSTEM

In an October 2014 report, Northern Virginia Technology Council found that the VA's current scheduling procedures and systems are insufficient and unable to meet the needs of America's veterans. The report also showed that these scheduling practices have resulted in errors made by staff and, therefore, further delays for veterans.

More recently, the GAO report on wait times also showed problems with scheduling specifically regarding mental health care.

It is becoming clear that a major cause of the VA's ongoing backlog is a—is the result of inadequate and outdated scheduling procedures. Issues like this have caused the American people to lose their trust in the VA.

Mrs. Halliday, do you agree with the findings in these reports, and can you provide more insight into the problems with the current scheduling process and how this affects veterans?

Mrs. HALLIDAY. Scheduling practices through VA need to be tightened up. We continue to receive allegations of problems with recording wait times. So I do agree that it remains a problem.

I think they need a new scheduling system. I think we went on record saying that back when we completed the Phoenix work. It was very clear that, again, another legacy system that was not really meeting the demands for the day.

So I do agree. I do think that VA has tried to get compliance with all of its scheduling procedures. I also believe VA has made an honest effort to try and train the schedulers so that there is no confusion and to ensure that they do this right.

There are some 35,000 schedulers VA-wide, so that is quite a task. And that piece of it has, I think, been addressed. The effectiveness of VA's efforts is going to depend on how religious the schedulers are to following those procedures.

DISCREPANCY IN REGIONAL OFFICE SERVICE QUALITY

Mr. VALADAO. All right. Then on another topic, my office provides Central Valley's veterans services to help them navigate the VA and make sure they get quality care. My staff has run into roadblocks that continually show problems with the VA.

Just this past Tuesday a constituent working with my office found out that a video conference request to appeal his case with the VBA was simply lost in the cracks. The VBA has lost his request and has—and had instead assigned him to a much longer appeal process.

When my staff attempted to help the constituent we could not get ahold of anyone at the L.A. regional office, where his case was assigned. Instead we had to contact the Oakland office and they told us that the original request of appeal was never filed—was never added to his file.

My constituent has now been waiting for over a year and now must wait even longer. This not only shows a breakdown in record-keeping, but a discrepancy in the quality of service between regional offices.

Mrs. Halliday, has the I.G.'s office noticed—to record something as simple as a type of appeal request?

Mrs. HALLIDAY. We do get contacts in our OIG hotline, and we do look at those for any type of trend where there is a problem there. It has been a longstanding OIG practice that when a problem comes in from a veteran, it is immediately transferred over to VBA to take action on it.

It is unfortunate, but there are some, you know, problems with veterans being a little confused on how to apply for care. A lot of VSOs provide assistance. I would absolutely encourage you and your office to make sure veterans are working with the VSOs.

Mr. VALADAO. In this case specifically, my office reached out to the L.A. office; L.A. would not respond and wouldn't communicate back to us and just completely ignored us, and so we had to deal with the Oakland office. Are procedures the same throughout all your offices?

Mrs. HALLIDAY. The procedures are going to vary, and they are not my offices. You need to refer that complaint directly to VA, and it should go down to the Acting Under Secretary for Benefits, Danny Pummill, to address. Veterans should be able to get an answer when they call in and need help.

It is the same situation we are finding with the call centers, which would be a little bit different than going down to the VARO site. That is unacceptable service.

Mr. VALADAO. All right.

I think that is all I have got. Thank you.

Mr. DENT. Thank you, Mr. Valadao.

We will move into the second round of questioning right now, and I might actually recognize Mr. Bishop first. I think he has another hearing he must attend.

REVIEW OF VA CONSTRUCTION CONTRACTS

Mr. BISHOP. I do. Thank you. Thank you very much, Mr. Chairman.

Mrs. Halliday, as you know, with Denver construction remains a concern for this subcommittee. Since I have been the ranking member we have taken small steps each year to make the VA better at its construction processes.

Have you seen any changes in the way that VA approaches the construction process? And has the VA taken steps to avoid another Denver situation?

As you know, the contract review—the Office of Contract Review falls under the supervision of the counselor of the I.G. And last time I asked the question I don't believe that a comment could be given. So has there been any review of the Denver Medical Center contract, and does the I.G. plan to spot-check construction projects in the future?

And finally, is the VA performing, in your opinion, in accordance with the construction standards of its own—and its own policies? And have you performed a compliance review of their activities?

Mrs. HALLIDAY. The Denver Medical Center, the replacement of it, posed significant challenges dealing with the general contractor and getting agreement with VA. There was a court case that addressed the first level of expenditures to approximately \$600 million.

I have work in progress right now, but the group that is doing the work is not only tasked with looking at whether the controls that have been put in place now to control Denver—its cost, its schedule, and any of the residual risks associated with building that site—but have been effective also to take a much broader look at VA's construction program. Does VA have the right policies, the right procedures as to what it needs?

That report—I don't have it in my hands yet. I know it is in the works. Several site visits have been done both at Denver and at headquarters.

I would say that the decision to take and put the Army Corps of Engineers over the site is a good decision. VA doesn't have the right resources to do many of these builds, and the Army Corps of Engineers does. But there are still controls that have to be put in place over costs to make sure you get the buildings built to the requirements you need.

That is really important. It has been a weakness in VA for years, and that is the area they will have to focus on because they have to tell the Army Corps of Engineers what they need and where they need it built so that it meets requirements for the future. A lot of these projects have taken so long it is hard to ensure they will meet the future requirements because the specs were designed, or the requirements for the medical center determined, years earlier.

I do think that Mr. Gibson has made a concerted effort to try and make sure this construction moves along. Nobody wanted a situation where Denver remained unusable, and it needed to be built. It is much bigger than just a traditional medical center, so I hope that my office can get a report out in the next quarter that lays out more of the controls that VA might need to shore up moving forward.

I have been, just as Dr. Daigh had said, in contact with the Office of Acquisition, Logistics, and Construction to tell them some of

my concerns that the team was raising early on. I am not leaving it to the end of our work. I don't think that is a way to run a good program.

I think you need to tell them, "I have a concern here. You need to address it." And they have been very receptive to that.

Mr. BISHOP. Thank you very much.

Mr. DENT. Thank you, Mr. Bishop. We will try to go through this round as quickly as we can.

MERIT SYSTEMS PROTECTION BOARD APPEALS

This time I will ask a few questions.

Mrs. Halliday, in three recent cases your office recommended punitive actions against three senior VA employees. VA reviewed your recommendation and then issued penalties, although not as severe as your office had recommended, to those three employees.

Those employees appealed their case to the Merit Systems Protection Board. Amazingly, the board overturned VA's action.

What do these decisions tell you about the board's stance in these types of disputes? Will the VA ever be able to fire a senior employee or is VA botching its personnel actions?

Mrs. HALLIDAY. I definitely think there is a problem with the law that MSPB could not mitigate the proposed disciplinary actions. The MSPB found that there were problems with two of the relocations, but because they don't have the authority to put a lesser disciplinary action in place, MSPB's only option was to overturn the demotions entirely.

So the problem is with the law more than anything, and I also think the new expedited process presents challenges for VA to try to make sure everything is done correctly within that new time-frame set for senior executives.

Mr. DENT. So it is the law then. You think we need to address the law, then, to—

Mrs. HALLIDAY. I think you need to address the law. Even if the department and the OIG agree to disagree, there were merits to the conclusions we drew in those reports and we still feel comfortable with those. It is the department's responsibility, not the OIG's, to determine the disciplinary action, and they need to weigh that based on the actions that occurred and apply it consistently across all of VA.

PHILADELPHIA OFFICE PERFORMANCE

Mr. DENT. One of the cases involved the Philadelphia Philadelphia regional office. Your office released a pretty damning report on that office last spring and you attended a town hall meeting that I and several members of the Pennsylvania delegation held at the office, plus members from other parts of the country attended, as well from the authorizing committee.

We heard many of the stories of employer mismanagement and low morale, and yes, it was pretty clear a lot of relationships needed to be reconstructed. It was a bad situation.

What progress has the Philadelphia office made in response to your report, and will the reinstatement of the disciplined employees turn back the clock to the spring of 2015?

Mrs. HALLIDAY. I believe, as I said up in that meeting, that we were going to give that VARO a year to implement and we would be back in to do follow up. There is some ongoing work with our Office of Investigations there, and that is exactly what we are doing.

We did look into one instance that was asked by the HVAC Chairman, but we closed the issue after we learned VBA had already addressed the matter we intend to go back in there.

With regards to putting the senior executive back in place, that senior executive was not a contributing factor to all the problems we reviewed because she was not in place at that time. My understanding is she came in right about the same time we were in there looking at the manipulation of data based on compliance with the Fast Letter. And that is what started all the work in Philadelphia.

Again, I would say the same thing I said to Mr. Fortenberry. It is the department's decision to put her back in place.

Mr. DENT. Right.

Mrs. HALLIDAY. She has a good career record of doing things well for veterans. It has to be looked at over time.

DEPARTMENT OF JUSTICE REVIEW

Mr. DENT. Understood.

And finally, I just wanted to ask, too, in a number of cases your office has forwarded reports of senior staff misconduct to the Justice Department for prosecution, and Justice has declined to accept those cases. Why is Justice refusing to accept those cases, and what disciplinary recourse does VA have when the cases are rejected?

Mrs. HALLIDAY. We did due diligence and submitted that case over to the Department of Justice for them to review. That doesn't just mean the decision is made at that point. The Department of Justice will review it; they will look and see if they want more evidence collected.

But in this particular case they did not want to take the case. In this type of case, trying to prove intent is very hard.

Multiple factors including financial thresholds come into play regarding which cases the Department of Justice takes and which ones they do not.

Even if DOJ declines to take it that still doesn't mean it's the end of the road. The case then goes to the department and they can apply appropriate disciplinary action, which is their job.

And that is why we go from DOJ over to the Office of Accountability Review, but we do not tell them what disciplinary action they have to take. They need to apply their management judgment on that.

Mr. DENT. Thank you.

And at this time I would recognize Mrs. Roby, for 5 minutes.

Mrs. ROBY. Sorry for the running back and forth. We have got a lot of hearings going on. So, Chairman, thank you.

IDENTIFICATION OF WASTE, FRAUD AND ABUSE

You indicated in your testimony that your organization delivered \$2.2 billion in monetary benefits in terms of waste, fraud, and abuse that you uncovered. So relative to your fiscal year 2016 en-

acted budget of \$138 million for fiscal year 2016 that is a 20-to-1 return on investment.

That, to me, is a good-news story, although I am sorry to see that there is so much waste, fraud, and abuse within the system. We are talking about billions of dollars here.

At the same time, you were recently quoted in the media stating that your office is only investigating 10 percent of the 40,000 complaints it receives annually about problems at the VA. Is that an accurate number?

Mrs. HALLIDAY. That was not a quote. What I said was that we get approximately 38,000–39,000 contacts annually via the hotline. And again, I reiterated in this statement that every contact is reviewed, triaged, and undergoes a risk assessment so that our staff can determine the merits of the work.

It is not that we ignore 36,000 contacts. There is a paring down process to determine if they fall under our authority or another Federal agency such as the Office of Special Counsel. We must determine if there is enough clarity in the allegation that allows it to be reviewable.

There are many factors that come into play.

Mrs. ROBY. Do you have a breakdown of those numbers specifically? As you looked at the other 36,000 cases, you know, how many of those did you determine were not worthy of further investigation, and then the ones that were? How do you—

Mrs. HALLIDAY. I don't have empirical data. I did ask the hotline group to lay it out and take all the information for a week.

We have been meeting weekly on every bit of this to make sure that we are not missing work that we should be taking, especially if, say, David Daigh's office says, "I've got everybody assigned. There is no way I can add more work." Well, there are still options for us as an organization.

Would it go to the Office of Audit? Could it be done by the Administrative Investigations Division? And I want to make sure that those decisions are risk-based and prioritized correctly so that we do that.

I think my prior testimony was misinterpreted to suggest we are just ignoring the 36,000 or so that don't result in an open case.

Mrs. ROBY. Today is your opportunity to tell us otherwise.

Mrs. HALLIDAY. That is not the case.

BUDGET IMPACT IG CASELOAD

Mrs. ROBY. OK. And just to add onto that, with your request in the President's budget today, how do you think—because you are here to justify that to this committee—how do you think that that number will impact your ability to dip beyond the tip of the iceberg, so to speak, on the number of cases that need to be investigated?

Mrs. HALLIDAY. One of the first things that I looked at was the number of allegations we believed had merits and should receive some level of review, but that we didn't have the staff resources to review ourselves, and those were referred to VA for review. And that was an understandable source of concern for whistleblowers that we would hand this information over to VA for them to do their own review and decide if the results were acceptable.

I would like to take a lot of that work and do it with our in-house staff. I think it fixes two problems: it brings quality and consistency across the reviews of allegations that are being done, and it really helps us address some whistleblower concerns that were just outside of our control.

IMPROVEMENTS TO SUICIDE HOTLINE

Mrs. ROBY. And with the mental health—on the mental health side, with the suicide hotline—I know there have been several members that have touched on that, but—you know, this is astounding to me and I want to know what you guys are doing to ensure that the individuals that slip through the cracks—what has happened? You know, how are you ensuring that those people are being touched?

And are you confident that the corrective actions that the VA has undertaken are sufficient? Because I don't. I mean, that is not the anecdotal—that is not what I am hearing through my VA.

And this is a tragedy in our country, and so I just—I want to know how confident you are in the suggestions that you are making to—for improvements in this area.

Dr. DAIGH. So I think with respect to the Canandaigua hotline, I think that some of those calls were probably lost and not recoverable, so I think there is some unknown number of calls that we don't know or were not returned back or not—veterans not contacted.

I believe that VA has put the changes in place so that calls are currently answered.

When this story broke and we published our report, the DOD I.G. had also had communication with this group, and so they submitted to me the issues they had with Canandaigua. So Dr. Shepherd of the OIG will go back up and visit and make sure that the changes are actually in place.

But we are very vested in this hotline. You may not know that as part of the genesis of this idea, Dr. Shepherd and I and others were among those who decided collectively that this might be a good idea.

There were many, many parents of this idea, but we want it to work. It needs to work. I will do everything I can to ensure that it does work. Right now I believe it is working properly.

RECOVERY AUDIT PROGRAM

Mrs. ROBY. I have one last issue and my time is running short so it may be something that I have to get from you later regarding the Medicare estimates that more than 10 percent of their fee-for-service payments were improper. Medicare employs many approaches, including some recovery audits.

What are your thoughts about the VA initiating some kind of third-party recovery audit program, like what Medicare does, in addition to some of the rudimentary safeguards handled by the insurers? Or maybe you are already doing it.

And my time is expired, and to be respectful to the other members of the committee, if you could get back to me on that I would be very appreciative to know how you are handling—

Mrs. HALLIDAY. Yes.

[The information follows:]

VA's Chief Business Office (CBO) had a recovery audit contract with Health Net to review inpatient Non-VA Care payments. This contractor was paid based on the amount of overpayments recovered. The contract with Health Net expired in 2012. The Financial Services Center in Austin, Texas, which is a part of VA's Office of Finance, also offers recovery audit services. Employing recovery audits would improve VA's ability to recover any overpayments.

Mrs. ROBY [continuing]. That. Thank you.
I yield back.

Mr. DENT. Well, thank you, Mrs. Roby.

And, yes, please respond to her request for an answer to that question. Thank you.

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

LATE PAYMENTS IN CHOICE PROGRAM

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Is there a problem with late payments to veterans who have been participating in the Veterans Choice Program—to the medical providers of veterans who have been participating in the Choice Program?

Mrs. HALLIDAY. Yes.

Mr. FORTENBERRY. OK. Why don't you unpack that further?

Mrs. HALLIDAY. We are looking at this issue right now. I think I might have said something when you were out.

We have a requirement to look at all the expenditures under Choice and report to the Congress once 75 percent of the expenditures are made. I made a decision that that is too late in the process, that we need to be looking at it now, and I directed our teams to look at each fiscal quarter to be able to determine whether the problem is getting better or worse.

The audit and oversight work of Choice didn't start as quickly as the funding came to VA because the expenditure level stayed so low. But then we realized the issue is not the expenditure level, it is what is not being paid.

So there are teams concentrating on that right now. I don't have the empirical evidence yet, but we expect that we will have national samples.

Mr. FORTENBERRY. Well, the policy issue is clear, that if we are going to, again, help meet the mission of the VA in a more creative manner by leveraging private sector resources when necessary, that they have to be available to us and not unwilling to take on veterans because they don't get paid. Or the pay is so delayed that it causes difficulty. So that is the underlying policy issue.

ROLE OF IG IN LEGISLATION

This begs the further question, and it is a larger question, about the role of the inspector general in general. Do you bring legislative recommendations to us?

Mrs. HALLIDAY. We do make legislative recommendations at times, though probably not as many as the VA makes. But where we see we need access to more information so that we can do our jobs better, we clearly do that.

If we think the department needs to fix something, we would address that, too.

Mr. FORTENBERRY. You bring them directly to the department, or you bring them to Congress?

Mrs. HALLIDAY. To Congress. You know, I would have to look at that.

Mr. FORTENBERRY. Well, here is the reason I am asking it is—

Mrs. HALLIDAY. Yes. I would have to check that for sure.

[The information follows:]

Under Section 4 of the Inspector General Act, OIGs can review existing and proposed legislation and regulations relating to programs and operations of their departments and make recommendations in the Semiannual Report to Congress. The VA OIG has also commented on legislation in response to congressional requests outside of the Semiannual Report. We have also made recommendations to VA in our reports that VA should consider proposing legislation to address issues that may need a legislative fix.

Mr. FORTENBERRY. Well, and I don't know if there is some requirement or non-requirement or some cultural bias against doing it, but all of our questions are hinting at—what they are hinting at is how we deliver the most effective service to our veterans. And when you analyze some breakdown, wherever it is, and present us the findings, it is of course helpful to know that, but Congress itself has capacity problems.

So to devise solutions—legislative solutions that would not only help you meet your own mission of more flexibility, efficiency in your own dealings of oversight, but fixing the underlying problems that the oversight is pointing to and recommending those back to us, actually would be a very helpful shift of mission.

Now, I don't know if there is any prescription or proscription on that. I don't think there is. But I would just offer that to you by way of suggestion, in terms of your own internal culture.

Dr. DAIGH. I would say that we work with both the Senate and House Veterans Affairs Committees' staffers extensively. Every time we write a report we are almost always up briefing and talking about what needs to be fixed.

So in the form of us writing proposed legislation and giving it to them, we don't do that very often. But in terms of talking about problems and solutions, we do that all the time.

So there is a more formal process that we would have to get back to you on concerning exactly how the OIG would submit it through the Government to have you look at that, but informally, we have constant discussion about that in terms of what the problems are. And when it gets to whether is it a rule or is it a law or how to best solve it, then really the staff—we work with the staffers and they—

Mr. FORTENBERRY. Well, yes. And sometimes it just comes down to leadership. I mean, if you want to make a decision that this is important based upon the tone of the conversation that is coming out of these hearings, I would certainly welcome that. I am telling you that directly.

All right. Thank you.

Thank you, Mr. Chairman.

Mr. DENT. Thank you, Mr. Fortenberry.

At this time I would like to recognize Mr. Joyce, for 5 minutes.

JUSTICE DEPARTMENT PROSECUTION

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

I want to address something, Mrs. Halliday, that you said before. You refer cases to the Department of Justice and they refuse to act based upon a monetary figure or dollar amount. Is there amount that they refuse to look at?

Mrs. HALLIDAY. From my understanding with talking to my Assistant Inspector General for Investigations, it varies across localities.

Mr. JOYCE. Can you give me an idea what that dollar amount might be?

Mrs. HALLIDAY. I will give it to you for the record so that I am right. I know it varies. They want to get cases that they can take through prosecution, too. And some cases are just more difficult than others.

I think that there is a good effort to try and take all those that could result in a criminal violation.

[The information follows:]

The OIG investigates allegations of criminal wrongdoing. Prosecution decisions are made by legal authorities such as Offices of US Attorneys. We can and do make referrals to local prosecuting authorities as well.

Title 9 of the U.S. Attorney's Manual (Manual) outlines Department of Justice policy and responsibilities pertaining to the enforcement of Federal criminal laws.³

Title 9-27.110 specifically states, "Under the Federal criminal justice system, the prosecutor has wide latitude in determining when, whom, how, and even whether to prosecute for apparent violations of Federal criminal law. The prosecutor's broad discretion in such areas as initiating or foregoing prosecutions, selecting or recommending specific charges, and terminating prosecutions by accepting guilty pleas has been recognized on numerous occasions by the courts."

Title 9-27.220 specifically discusses grounds for commencing or declining prosecution. Specifically, the Manual states that, "The attorney for the government should commence or recommend Federal prosecution if he/she believes that the person's conduct constitutes a Federal offense and that the admissible evidence will probably be sufficient to obtain and sustain a conviction, unless, in his/her judgment, prosecution should be declined because:

- No substantial Federal interest would be served by prosecution,
- The person is subject to effective prosecution in another jurisdiction, or
- There exists an adequate non-criminal alternative to prosecution."

The Manual stipulates that when determining whether prosecution of a person's conduct would constitute a substantial Federal interest, the U.S. Attorney should weigh a range of relevant considerations, including:

- Federal law enforcement priorities,
- The nature and seriousness of the offense,
- The deterrent effect of prosecution,
- The person's culpability in connection with the offense;
- The person's history with respect to criminal activity,
- The person's willingness to cooperate in the investigation or prosecution of others, and
- The probable sentence or other consequences if the person is convicted.

³ See Title 9 - Criminal of United States Attorney's Manual. <https://www.justice.gov/usam/united-states-attorneys-manual>. Accessed March 14, 2016.

With regard to Federal law enforcement priorities, the Manual specifically states:

"Federal law enforcement resources and Federal judicial resources are not sufficient to permit prosecution of every alleged offense over which Federal jurisdiction exists. Accordingly, in the interest of allocating its limited resources so as to achieve an effective nationwide law enforcement program, from time to time the Department establishes national investigative and prosecutorial

priorities. These priorities are designed to focus Federal law enforcement efforts on those matters within the Federal jurisdiction that are most deserving of Federal attention and are most likely to be handled effectively at the Federal level. In addition, individual United States Attorneys may establish their own priorities, within the national priorities, in order to concentrate their resources on problems of particular local or regional significance. In weighing the Federal interest in a particular prosecution, the attorney for the government should give careful consideration to the extent to which prosecution would accord with established priorities."

Mr. JOYCE. Well, certainly you would agree with me that someone who has criminal intent to steal even a dollar from the VA that they should be prosecuted?

Mrs. HALLIDAY. I believe they should get some form of disciplinary action and that the action, whatever they have done, needs to be fully reviewed and appropriate discipline applied.

Mr. JOYCE. They should be fired and prosecuted, in other words. But I am just saying my suggestion would be that if you have not looked at it before, if the DOJ doesn't want to take it because they are too busy or it is not a big enough profile for them that maybe we should look at the state prosecutors. Because again, this is government money that is stolen if there is criminal intent there, or defrauded from the agency, and it should be prosecuted to the fullest extent of the law.

IMPACT OF INCREASING STAFFING LEVELS

I also wanted to follow up, in the budget authority amount there is an increase in full-time equivalents that specify your goal is to put staffing levels back on track. The new full-time employees would support oversight activities including those germane to health care.

This issue is extremely important to me. Can you please tell me and the rest of the members of the subcommittee how increased funding and a boost in personnel would positively impact effects to ensure our veterans are receiving the high-quality mental care that they so richly deserve?

Mrs. HALLIDAY. Absolutely. It gives us the capacity to do more reviews, both from a national level, regional level, and deal with some of those specific issues affecting veterans that when we look at those we then learn whether we need to look at it nationally.

It is the capacity to put more teams on variable issues and to, you know, address them. It isn't just one issue affecting veterans in mental health. It is many issues, whether they are in an alcohol dependency program, a drug dependency program.

There are so many variations, for example, Dr. Daigh has stated he can take about 60 allegations per year and publish reports on them. This is just the hotline allegations. But, in addition, his office and his clinicians bring a lot of information to the table to know which programs should be reviewed proactively without necessarily a specific allegation because those programs don't seem to be meeting their performance metrics.

So it helps with the capacity. It increases the number of teams. It increases our presence at medical facilities, and we get more information so we can provide the right recommendations.

Mr. JOYCE. Well, that is good to hear, and hopefully that plan will come to fruition soon and take care of those people.

HOTLINE DROPPED CALLS

Dr. Daigh, you brought up a point before that, you know, some of these calls have fallen through the cracks. Multiple cracks. I guess there are in such a system.

Is there no recordkeeping there? I mean, if someone calls in don't you—can't you ascertain the phone number from which someone has called?

Dr. DAIGH. I will have to get back exactly what the defects were, but it is my understanding that there were some calls that were left on voicemail for which it wasn't clear exactly why they couldn't get back to the people that made the call. So again, I will get back to you for the record on that.

I understand you have a lot of information about incoming data on a telephone; you ought to be able to do a lot of things. If a call is referred from one system to another system maybe some of that data is lost. But I will get back specifically about that.

[The information follows:]

During FY 2014, the Veterans Crisis Line (VCL) received three complaints concerning calls being directed to voicemail. VCL management reported to the OIG that each complaint was investigated and during VA's investigation, they found that calls were being routed to a voicemail system at a backup center. VA estimated that the voicemail system had been in operation approximately 2 years. They were unable to estimate how many calls went to the voicemail system but they were able to retrieve 20 messages. No time or date information was recorded in the voicemail system; however, if there was enough caller information in the voicemail itself VCL staff did contact the caller. According to the information provided by VA to the OIG, there were 5 voicemails out of 20 that did not receive follow-up due to a lack of information. We substantiated the allegations that some calls routed to crisis backup centers went into a voicemail system and that the VCL and backup center staff did not always offer immediate assistance to callers. In addition, we found that callers could be placed on hold in a backup center queue or be passed through several backup centers for an unknown period of time, which could account for the perception that the calls were not answered. We recommended that the Office of Mental Health Operations Executive Director ensure that issues regarding response hold times when callers are routed to backup crisis centers are addressed and that data is collected, analyzed, tracked, and trended on an ongoing basis to identify system issues.

BLUE RIBBON COMMITTEE

Mr. JOYCE. That would be great.

And one last quick question for you, Mrs. Halliday: I understand there is a blue ribbon committee, for lack of a better term, that has been reviewing the oversight of VA and how to improve. Has your office been called upon at all to testify before that committee or to give any input?

Mrs. HALLIDAY. No.

Mr. JOYCE. All right. Thank you very much.

I yield back, Mr. Chairman.

Mr. DENT. Mr. Jolly, you have no questions?

Well, then that would conclude the hearing. I just wanted to just state for the record I do have two additional questions that I will submit for the record that you can respond to then.

Thank you very much.

So, Mr. Bishop, any final words?

Mr. BISHOP. No final words.

I thank you very much for your testimony and all your work. And we look forward to continuing to work with you to support a very, very important mission.

Mrs. HALLIDAY. Thank you.

Mr. DENT. And I would just like to remind members tomorrow morning we have another hearing at 9:30 a.m. in this room. Tomorrow morning, 9:30 a.m., another hearing.

So thank you. This meeting is adjourned.

[Questions for the Record submitted by Congressman Dent for the Mrs. Linda A. Halliday follows:]

Question: Mrs. Halliday: What efforts has your office led, or otherwise been incorporated with or made aware of, to investigate allegations of abuse by for-profit colleges against veterans utilizing Post-9/11 GI Bill benefits?

Answer: We are currently in the planning stages of an audit on the effectiveness of State Approving Agencies' and VA's oversight of schools and programs that receive Post-9/11 GI Bill and other VA education benefits. Specifically, we will look to evaluate whether State Approving Agency and VA review, approval, and monitoring processes are effective in ensuring only eligible schools and programs receive education benefit payments. This audit will include reviews of accredited and non-accredited for-profit educational institutions, and it will provide information that we can use to identify and investigate possible fraud and abuse perpetrated by for-profit schools and programs.

Question: Your office came under fire last year for declining to release to Congress the reports and interim work products from all your investigations, including those you closed without action. Your predecessor was changing that policy to make more information available. Please update us on your current policy on report release.

Answer: The OIG conducts investigations, audits, reviews, evaluations, and inspections, and goes to considerable lengths to make the results of our work public through our website, www.va.gov/oig. Under some circumstances, we cannot release information due to Federal laws such as the Privacy Act and other confidentiality statutes. However in an effort to better inform the public and key stakeholders, we have undertaken efforts to issue work products in a manner and format that adheres with controlling law, regulations, and policies and directives. An example of this effort is the recent release of OIG work regarding allegations of wait time manipulation. These summaries provide Congress, veterans, and the public information on the OIG work conducted while adhering to confidentiality and privacy rules and protects whistleblower disclosures and identities.

In the interest of maximizing the use of our limited resources, once we determine an allegation is unsubstantiated we terminate the investigation, audit, review, evaluation, or inspection without a formal report as an "administrative closure" so that we can move on to other work. Until recently, we did not publish administrative closures on our public website. However, on March 17, 2015, under the leadership of then-Deputy Inspector General, the OIG released the following statement outlining our updated policy on publishing Office of Healthcare Inspections administrative closures:

"As a result of a review of Office of Inspector General decision-making practices on closing reviews administratively, the Deputy Inspector General instituted a new policy requiring coordination of administrative closures within the Immediate Office of the Inspector General, the Office of the Counselor to the Inspector

General, and the Release of Information Office. This process will ensure consistency in decision-making regarding when and how public release of related documents is handled. The Deputy Inspector General also directed a retrospective review of administrative closures by the Office of Healthcare Inspections from fiscal year 2014 to present. Based on this review, we have begun publishing administrative closure reports on the OIG website. Additional reports will be published pursuant to the Freedom of Information Act as we complete the process of reviewing and redacting sensitive information."

This policy remains in effect, although we have made a concerted effort whenever possible to avoid closing out work with administrative closures and, instead, opt to publish a final report of the unsubstantiated findings. Although the process of publishing a final report requires significantly more time and staff resources than issuing an administrative closure, and although we would prefer to invest these limited time and staff resources on other high risk reviews that we believe to be more meaningful to veterans and the VA, the OIG is committed to continuing this process as it demonstrates to Congress and the public our commitment to transparency concerning our work to the extent that the law allows.

Question: The President's budget request for your office is very generous – a 17 percent funding, and 100 FTE, increase. We were a bit surprised to see that the Independent Budget released by the VSOs proposed only a \$1M increase for the IG, saying that your FY16 appropriation should allow you to expand your staffing sufficiently to meet the growing demands on your office. How have you responded to the VSOs' funding recommendation?

Answer: Upon assuming the role of the Deputy Inspector General, Mrs. Halliday proactively met with several executive directors of the larger Veterans Service Organizations (VSO) to establish lines of communication, and the OIG's strained resources and significant uptick in Hotline complaints were among the topics of discussion.

The VSOs' fiscal year (FY) 2017 Independent Budget (IB) recommends an OIG budget of \$138,440,000, which is a \$1.674 million increase over the FY 2016 enacted appropriation of \$136,766,000. Over the past 4 years, the IB has recommended an average increase of \$1.8 million over the prior years' enacted appropriation for the OIG, so the FY 2017 IB recommendation is largely consistent with this average. The FY 2017 IB recommendation for the OIG also represents a \$10.028 million increase over the IB's FY 2016 recommendation.

Historical Perspective of VSO IB Recommendations for the OIG (Dollars in Thousands)			
FY	IB Recommendation	Recommended Increase Over Prior Years' Enacted Appropriation	Change From Prior Years' IB Recommendation
2017	\$138,440	\$1,674	\$10,028
2016	\$128,412	\$2,001	\$5,401
2015	\$123,011	\$1,600	\$7,958
2014	\$115,053	\$2,053	-\$0.555

As was presented in the OIG's statement for the hearing, the President's request for the OIG for FY 2016 would have necessitated a cut of 10 fulltime equivalents (FTE). While we are especially grateful to the Congress for the increase of \$10 million over the President's FY 2016 request, which instead allows us to increase our staff by 20 FTEs, we believe that the OIG continues to lack the resources needed to conduct proper oversight of VA's growing programs and operations. We view FY 2016 as the first step in right sizing the OIG's budget and staffing levels to an appropriate ratio given the size, scope, and complexity of VA's mission and organization.

We would also note that the VSOs' Independent Budget was presented without discussion or consideration of changes in work requirements. We have begun to define and implement a budget formulation process that offers more communications between the OIG and VSOs moving forward.

Question: Have you filled the 20 new positions that the FY16 appropriations act funded? How many on-board employees do you currently have? Now many do you expect to have by the end of FY16?

Answer: VA OIG has made significant progress to fill a minimum of 30 additional positions during FY 2016. As of March 7, 2016, our onboard strength has risen to 679 FTE and we have made selections for an additional 13 positions. This represents significant progress despite additional vacancies associated with the Inspector General and other Senior Executive positions and anticipated losses associated with retirements and other attritions at the level of GS-15 and below.

[Questions for the Record submitted by Congressman Rooney for Mrs. Linda A. Halliday follows:]

In a review of allegations of patient scheduling issues at the James A. Haley Medical Center in Tampa, FL, your office concluded that when veterans were able to schedule earlier appointments at other facilities utilizing the Veterans Choice Program, staff at James A. Haley did not cancel those veterans' existing appointments. What's worse, VA staff were found to have inappropriately removed veterans from the Veterans Choice List. Your office also found that a VA contractor, Health Net, failed to promptly notify VA care coordination staff when veterans had scheduled a new appointment through the Choice Program. The failure to free up these time slots for other veterans waiting in the queue is, from my perspective, a negligent practice that should have been addressed well before it rose to the level of an Inspector General audit.

Question: What is the root cause of these types of careless clerical errors that are occurring between different departmental staff? Why do you think this issue wasn't addressed earlier before becoming so pervasive that it warranted an audit?

Answer: OIG audits, reviews, and inspections have identified inadequate contracting development and oversight, staff training, and unclear policies and procedures as common causes for many of the problems VA encounters in its programs, not just at this one facility or limited to patient scheduling. The OIG has also recommended the replacement of VA's antiquated scheduling system.

Question: What practical steps does the VA need to take to ensure appointments are being processed correctly and that people in other departments are being updated in a timely manner?

Answer: As we have recommended in our reports, VA needs to ensure staff are properly trained on the policy and management of the Choice list to ensure staff add all eligible veterans to the Choice list and that veterans needing healthcare services remain on the Choice list. We also recommended that VA hold Health Net and TriWest accountable for providing timely notifications when veterans schedule and receive care in the community.

Question: Is the VA scheduling process more effective when a contractor handles one aspect of scheduling and the VA staff handles the other? If so, what can we do to ensure that contractors are sharing the burden of responsibility of coordinating with the VA?

Answer: VA failed to include basic contract requirements to hold contractors accountable for timely notification of veterans' appointments. Additionally, the authorization and scheduling process is overly burdensome on the veteran. Health Net and TriWest coordinate care with the veteran and the VA medical staff often are not aware of problems or issues veterans are having until late in the process.

Question: There are several cases that call in to question Health Net's reputation, including a suspension by the Centers for Medicare and Medicaid Services, an investigation by the Connecticut Attorney General, and instances of medical data breaches. Can you explain what factors are considered by the VA prior to entering into these kinds of contracts? What can we do to ensure that contractors are held to a higher standard in providing and protecting our veterans health care?

Answer: The Federal Acquisition Regulation requires Contracting Officers to determine if the contractor can meet contract requirements prior to award. This is determined by reviewing government and public data bases, to determine if the contractor is on any excluded parties list, reviewing the contractor's past performance and integrity, perform a review to make an affirmative determination of responsibility, and searches on Dun and Bradstreet. The Contracting Officer can also review other sources such as publications, suppliers, subcontractors, customers of prospective contractor, financial instructions, business and trade associations and other government agencies.

[Questions for the Record submitted by Congressman Valadao for Mrs. Linda A. Halliday follows:]

Scheduling

In an October 2014 report, the Northern Virginia Technology Council found that the VA's current scheduling procedures and systems are insufficient and unable to meet the needs of America's veterans. The report also showed that these scheduling practices have resulted in errors made by staff and therefore, further delays for veterans. More recently, a GAO Report on Wait Times, also showed problems with scheduling, specifically regarding mental health care. It is becoming clear that a major cause of the VA's ongoing backlog is the result of inadequate and outdated scheduling procedures. Issues like this have caused the American people to lose their trust in the VA.

Question: Mrs. Halliday, do you agree with the findings in these reports and can you provide more insight into the problems with the current scheduling processes and how this affects veterans?

Answer: The Council's findings are similar to issues we have previously reported regarding access to care and wait time issues. To restore veterans' faith in the VA, the VA needs to implement controls to ensure consistent and accurate data entry and establish reliable and meaningful measures to evaluate veterans' timely access to care. Recent OIG reports continue to identify issues with veterans not receiving timely care after their initial enrollment, for specialty services, for follow up care, and for access to the Choice program.

Question: What types of suggestions would you have to make the scheduling process more efficient and beneficial to veterans?

Answer: Past and recent OIG reports have made recommendations for improving the scheduling process and veterans' access to care. Implementing actions to improve data integrity will help provide VA better oversight to identify potential scheduling and access issues, and implement corrective action plans. We have recommended that VHA:

- Increase training for schedulers.
- Provide oversight to ensure that training was completed.
- Initiate actions to update the electronic scheduling process.
- Create veteran-centric measures.
- Increase oversight of scheduling practices to include quality assurance reviews of scheduling accuracy, monitoring veteran phone calls to schedulers, and data validation of performance metrics.

Quality of Service

My office provides Central Valley veterans' services to help them navigate the VA and make sure they get quality care. My staff has run into roadblocks that continually show problems with the VA. Just this past Tuesday, a constituent working with my office found out that a video conference request to appeal his case with the VBA was simply lost in the cracks. The VBA had lost his request and had instead assigned him a much longer process of appeal. When my staff attempted to help the constituent, we could not get a hold of anyone at the LA Regional Office, where the case was assigned. Instead we had to contact the Oakland office. They told us that the original request of appeal was never added to his file. My constituent has now been waiting over a year and now must wait even longer. This not only shows a breakdown in record keeping, but a discrepancy in the quality of service between regional offices.

Question: Mrs. Halliday, has the IG's office noticed any similar problems with appeals in which the VA simply mishandles requests? If so, how is the current system failing to record something as simple as the type of appeal request?

Answer: The OIG Benefits Inspection teams have found isolated incidents where VA Regional Offices have not adequately managed formal hearing requests submitted by veterans. These incidents generally relate to not timely scheduling a hearing or simply forgetting to schedule the hearing. In April 2016, the OIG is initiating a review of VBA's appeal process that will look at all seven phases of the VBA appeal process. As a subset of that review, we will look at timeliness issues related to the formal hearing process.

Veterans Crisis Line

In a report released earlier this month, your office found that calls to the Veterans Crisis Line, a key part of the VA's suicide prevention program, were going to voicemail. The report found that social service assistants in the call center were not properly trained to for that job. I was fortunate enough to spend Christmas with our soldiers in Iraq, and during my time there I learned that 22 veterans commit suicide a day. The fact that our Veterans Administration could let the Crisis Line go to voicemail and leave our veterans in distress is a big problem.

Question: Dr. Daigh, you signed off on this report, can you provide more details on it and discuss why these calls were sent to voicemail?

Answer: The OIG received a series of allegations related to the Veterans Crisis Line (VCL) including calls going to voicemail. During our work, we substantiated that some calls routed to crisis backup centers went into a voicemail system. The VA contract with L2HS, which provides VCL with access to backup call centers, does not prohibit backup centers from using voicemail. VCL management told us that backup centers, though not prohibited by contract, should not use voicemail when answering calls for the VCL. VCL management reported that they are working with the Veterans Health

Administration to change the current requirement in the VA contract with L2HS, once the existing contract expires, to include a restriction on the use of voicemail.

Question: We first started hearing about major problems with the VA in 2014. It has almost been 2 years and we are still finding out about problems like the Crisis Line. What can we do in Congress to help your office find more problems like this so that we can come up with solutions?

Answer: The OIG is responsible for conducting oversight of all VA programs and operations. A properly funded OIG would allow for more oversight and allow for additional risk assessments which are critical as VA continues to send veterans outside the system for healthcare. The additional work would provide VA, the Congress, and veterans with more information on how VA operates and increase attention on those programs that present a challenge to VA. The OIG budget has grown since 2009 but the VA's budget and responsibilities have also grown at an exponential rate.

[Questions for the Record submitted by Congressman Bishop for Mrs. Linda A. Halliday follows:]

Question: According to the FY 2017 budget documents, the IG's request represents the first of what the VA says will be a sustained series of appropriation increase requests to "right size" OIG staffing levels to an appropriate ratio given the size, scope, and complexity of the VA mission and organization. Is there a plan associated with this increase that you could share with the Committee? In addition, what would the IG be able to do with additional resources?

Answer: The OIG's plan involves growing the organization to 1,160 full time equivalent employees from appropriation with a budget estimate of approximately \$234 million. This budgetary amount is based upon VA's appropriated FY 2016 budget and places VA OIG in better alignment with the resources provided to other OIGs across the Federal government. With support from the President and Congress, it is our intent to implement this plan over the course of 3 – 4 fiscal years. These resources would allow VA OIG to be better prepared to handle the increase in requests for reviews, inspections, and investigations that we have received through our Hotline and through Members of Congress.

The additional resources from these positions would support:

- An increase in OIG staff and offices across the country. This would allow the respond to the changing demographics and locations of current veterans. These offices would be staffed by auditors, analysts, health care professionals, criminal investigators, and benefits inspectors.
- An increase in Hotline analysts and rapid-response teams tasked with reviewing complaints received by the general public and recommending and conducting the corresponding VA OIG inspections. Presently, VA OIG is forced to triage and only accept the most serious allegations received through our OIG Hotline. The additional budgetary resources are critical in order for VA OIG to accept more cases in-house versus tasking the appropriate VA administrations with researching the allegations and providing an after action report to VA OIG.
- An increase in nationwide audits and inspections. Currently, VA OIG resources and pressing requests from the OIG Hotline and Congress limit our ability to do proactive work associated with the Choice Act, benefits adjudication processes, coordination of care between the Department of Defense and VA, VHA staffing and physician workload issues, the provision of mental health care, administrative reviews of senior VA officials, legacy financial and information technology applications, and other reviews of VA programs and operations.

Question: Can you explain the different ways this money is recovered and how is it reinvested back into the VA and is it safe to say the OIG will recover more with this higher funding level?

Answer: The OIG calculates monetary impact through better use of funds, questioned costs, savings and cost avoidance, and fines, penalties, restitutions, and civil judgements. Actual dollar recoveries such as fines, penalties, restitutions, and civil judgments are eventually returned to the U.S. Treasury and in some instances to VA's Revolving Supply Fund.

Money can be recovered through post-award reviews, either proactive or in response to voluntary disclosures or a case brought against a company under the qui tam provisions of the False Claims Act, when the review finds that the Government was overcharged for goods or services through defective pricing, charging more than the contract price, or failure to comply with contract terms and conditions, such as the Price Reductions Clause. If there is no evidence of fraud, the funds are recovered through a bill of collection or settlement agreement between the vendor and VA and the funds deposited in the Supply Fund, which is a revolving fund. If a case involving contract fraud is settled by the Department of Justice under the False Claims Act, the amount representing single damages is deposited in the Supply Fund.

The plan for the additional funds requested for FY 2017 includes an increase in investigators which would potentially increase the amount collected in fines, penalties, restitutions, and civil judgements. There would also be an increase in the number of audits which may allow for audit work in other high risk areas that would increase the number of audits and therefore the amount of the better use of funds and questioned costs.

Question: How many findings does the IG have against the VA currently and does the VA have a resolution process and a timeline for remedy?

Answer: As of March 7, 2016, the OIG is tracking 246 open reports with 1,275 recommendations for improvement with VA program offices. The total monetary benefit associated with these open recommendations is \$3,424,191,660. Most recommendations are currently tracking to close within 1 year of the VA OIG report publication. However, despite our quarterly communication with VA program offices on the implementation actions of open recommendations, there are currently 52 reports with 164 recommendations open over 1 year. The total monetary benefit attached to these older recommendations is \$2,433,162,198.

VA CONSTRUCTION

Question: The Denver, construction remains a concern for this subcommittee and the subcommittee has taken small steps each year to make the VA better at construction. Has the IG seen any changes in the way VA approaches the construction process? What steps has the VA taken steps to avoid another Denver situation?

Answer: The OIG is completing its report on the Denver construction project and we expect to issue a final report later in the Spring 2016.

In general, we have preliminarily concluded that the Denver project experienced significant, and unnecessary, cost overruns and schedule slippages largely due to poor business decisions and mismanagement by VA senior leaders concerning project planning and the design of the Denver replacement medical center. The VA did not ensure the project design could be built for the approved budget. A variety of other issues we identified also complicated and contributed to the delays and rising costs of the project.

We also learned during our work, that VA's Office of Acquisition, Logistics, and Construction was undergoing a number of internal and external evaluations regarding its staffing and processes in the construction program. The results of these evaluations should impact how VA handles construction projects in the future. Also, Public Law 114-58, Department of Veterans Affairs Expiring Authorities Act of 2015, requires the VA to enter into agreements with an appropriate non-Department Federal entity to provide full project management services for any "super construction projects" (projects estimated to cost over \$100 million). This shifts responsibility away from VA in an effort to prevent another mismanaged over-budget major construction project. VA shifted responsibility for the Denver project to US Army Corp of Engineers in October 2015, and plans for the Corp to manage all or portions of six other major construction projects with an estimated cost of more than \$3.6 billion.

Question: The Office of Contract Review falls under the supervision of the Counselor to the IG, has there been any review of the Denver Medical Center contract? Furthermore, does the IG plan to spot check construction projects in the future?

Answer: The Office of Contract Review did not review the Denver Medical Center contract. With respect to construction, reviews are limited to those requested by VA. These reviews include pre-award reviews of proposals for certain contracts and reviews of claims and change orders. In 2013, VA did request a review of vouchers for the Denver project but, due to inadequate staffing for construction reviews under the Memorandum of Understanding with VA, there were insufficient resources to conduct both the Denver review and a review requested on another large construction project. VA decided to have the Defense Contract Audit Agency conduct the review related to the Denver construction project. Later, the VA OIG did offer the services of the Office of Contract Review to review changes orders and other requests for payment; however, VA did not request a review.

Question: Is the VA performing in accordance with construction standards and its own policies and has the IG performed a compliance review of these activities.

Answer: OIG reported in December 2012, that VA was inappropriately supplementing minor construction projects with medical facility funds, project monitoring was

ineffective, and projects were constructed outside their approved scopes. In May 2014, we reported that the Veterans Health Administration's (VHA) Non-Recurring Maintenance Program did not have an adequate process to track how much medical facilities spent on their non-recurring maintenance, inadequately assessed risks to patient safety, and underestimated repair costs by \$12.3 billion. In both reports we recommended that VHA publish policy, develop procedures, and improve their monitoring of program compliance. With additional resources, we could conduct additional audits on VA's construction program.

VETERANS CRISIS LINE

Question: The OIG released a report earlier this month on caller response and quality assurance concerns within the Veteran Crisis Line. This inspection substantiated allegations that backup crisis centers routed some calls to voicemail, callers did not always receive immediate assistance from Veterans Crisis Line and/or backup center staff, and the Veterans Crisis Line did not provide social service assistants with adequate orientation and ongoing training. As you know, suicide amongst men and women who have served our great nation continues to be a serious problem. Can you please discuss some of the recommendations the IG report and the timeline for implementation?

Answer: The report made 7 recommendations to the Executive Director of the Office of Mental Health Operations. The Director concurred with the recommendations and provided implementation plans for the recommendations ranging from April 1, 2016 through September 30, 2016. The OIG will review information that VA provides to close these recommendations and advise accordingly. The OIG plans to conduct follow-up work after a sufficient amount of time has passed to allow for corrective action to be implemented.

[Questions for the Record submitted by Congressman Farr for Mrs. Linda A. Halliday follows:]

Question: What additional resources does the OIG need to develop a correctional action plan to improve the VA customer service experience?

Answer: The OIG has repeatedly made recommendation to VA that if implemented would improve the service provided to veterans throughout VA. We have focused in the past on veterans' initial contact with VA for service and benefits. We have a number of reports dealing with the many call centers VA operates. The continuing theme throughout those reports is that VA needs to establish standards for performance and to measure productivity. This will allow VA to better plan for staffing and better understand the types of problems that veteran experience in obtaining services from VA. We also reported on issues related to health eligibility enrollment and have additional work ongoing in that area. We are currently conducting a national audit of the Patient Advocacy Program to ensure VHA is adequately managing patient complaints. We will review a sample of complaints in the Patient Advocate Tracking system to review management; conduct tests with a focus on timeliness and adequacy of responses; and assess completeness of records. We expect to issue a final report by the end of fiscal year 2016. This work will go far in providing VA information on how to improve customer service to veterans. To do a nationwide review of how VA provides the multitude of services in its mission would be a labor intensive effort with a multidisciplinary team of about 20 full-time equivalents which would equate to \$4 million.

WEDNESDAY, MARCH 2, 2016.

DEPARTMENT OF VETERANS AFFAIRS

WITNESSES

ROBERT A. McDONALD, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS
DAVID J. SHULKIN, MD, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION
DANNY G.I. PUMMILL, ACTING UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION
RONALD E. WALTERS, INTERIM UNDER SECRETARY FOR MEMORIAL AFFAIRS, NATIONAL CEMETARY ADMINISTRATION
EDWARD JOSEPH MURRAY, INTERIM ASSISTANT SECRETARY FOR MANAGEMENT, INTERIM CHIEF INFORMATION OFFICER, OFFICE OF MANAGEMENT
LAVERNE H. COUNCIL, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY, CHIEF INFORMATION OFFICER, OFFICE OF INFORMATION AND TECHNOLOGY

CHAIRMAN'S OPENING STATEMENT

Mr. DENT [presiding]. Good morning. I would like to bring to order this meeting of the House Subcommittee on Military Construction and Veterans Affairs. Mr. Secretary and guests, we welcome you and your team here today to discuss the fiscal year 2017 budget request.

And I certainly appreciate, Mr. Secretary, your visit to the office last week. As we discussed, your budget request and those of all non-defense agencies face a high hurdle this year. The increases proposed, generally, are not built on a very solid foundation, in my view.

Redefining discretionary programs as mandatory and tax hikes for the middle class—that will not be entertained by this Congress. We have to work within the budget agreement we have, which, as I discussed with you, has only a \$40 million increase across all non-defense subcommittees from the fiscal year 2016 level.

Your budget requests say \$3.6 billion increase, which is going to be a real heavy lift, in this current environment. In addition, you are in the unenviable position of having to pick up the costs of the Choice program, as the mandatory spending, created by the authorizers, runs dry beginning in 2017 and in full force in 2018.

But we are, certainly, very interested in hearing your ideas about top funding priorities for the VA and for what you have been doing to improve management of the department. The roster of officials accompanying you today is a clear sign of some of the management changes you have made. I don't think a single one attended our budget hearing last year, if I am not mistaken.

But before I ask you to introduce your team and provide a summary of your written statement, I will, also, ask the ranking mem-

ber if he would like to make any opening remarks. Before I recognize him, I do want to say I know that we are in a difficult budget environment.

I, also, know, too, that the day is coming where we are going to have to figure out a way to better integrate the veterans and the civilian health systems, ensuring that veterans can be cared for in the communities where they live.

It is going to be increasingly difficult, over the long-term, to continue to build capacity within the VA system and to provide more choice, sustainably and simultaneously. It will be very difficult.

So I look forward to hearing your opening statement, Mr. Secretary. Before you begin, I would like to recognize my friend and colleague from Georgia, the Ranking Member, Mr. Bishop.

RANKING MEMBER'S OPENING STATEMENT

Mr. BISHOP. Thank you, very much, Mr. Chairman. And welcome, Mr. Secretary, and welcome to all of your team. You are very ably supported this morning, and we appreciate that, very much.

Mr. Chairman, I don't think anyone will ever be able to say that President Obama or this Congress, whether under Democratic control or Republican control, has not provided the proper resources to the Department of Veterans Administration.

Like in previous budget proposals, the VA's budget continues to grow. In fact, since 2009, total VA funding has grown by 86 percent. Let me just say that, again. Since 2009, it has grown 86 percent. How many other agencies can say that?

Fiscal year 2017, of course, is no different. The VA sees a healthy increase of 5 percent over the fiscal year 2016 enacted level in the request. When we included mandatory funding, the President's fiscal year 2017 VA budget proposal provides \$182 billion, a 9 percent increase over the VA's fiscal year 2016 funding, which is almost double the VA's 2009 budget.

Mr. Chairman, as we have discussed in detail, I am concerned about the future of the VA I believe that we need to provide the best care possible. However, I also believe that we need to control costs, so they don't spiral out of control. Furthermore, we need to make sure that the resources that the committee provides are used effectively and efficiently.

Furthermore, I am concerned about the current proposal for reform of the appeals process. As we know, the current process is complicated, ineffective, and veterans are waiting, on average, about 5 years for a final decision. And that wait is, certainly, unacceptable.

And I applaud you for trying to solve the problem, but I believe that this proposal needs a serious review. To me, it is unclear whether or not the authorizers are going to take up the proposal at all.

Another topic that I hope we can discuss today is the Veterans Experience Office, or the VEO. My understanding is that the VEO was established as part of the MyVA task force under the Office of Enterprise Integration in 2016.

This office has funding through the OEI reimbursements, and now the fiscal year 2017 budget proposes to make the VEO a standalone office within General Administration. Mr. Secretary, I

believe that you are honestly trying to make change at VA, and change needs to happen at VA.

But, as I look at the changes, like the VEO and the MyVA, my concern is that we are setting up programs at the VA, that the next Secretary may change and valuable resources may, ultimately, be wasted.

I want to make sure that the investments that the committee makes will stick. As you can see, we have a lot to discuss today. And I thank you for the opportunity to share my concerns.

And, with that, I will yield back. And, of course, after your testimony, we will have some questions for you.

Mr. DENT. I would like to thank the ranking member.

Before I recognize Secretary McDonald, I would like to recognize the full chairman of our committee, the gentleman from Kentucky, Mr. Rogers.

FULL COMMITTEE CHAIRMAN OPENING STATEMENT

Chairman ROGERS. Thank you, Mr. Chairman.

Mr. Secretary, guests, welcome. We appreciate your taking the time to be here and respond to our inquiries about your budget submission. VA is entrusted with one of the most central responsibilities of government, providing comprehensive care for our veterans and ensuring that they enjoy the highest quality of life, after they have served.

With a high number of young veterans returning from Iraq and Afghanistan, and the number of disabled veterans rising, the challenges facing your department are mounting on several fronts.

Our veterans deserve, and have been guaranteed, access to quality health care, timely decisions on their disability filings, as well as assistance with education and employment. And they look for your department to fulfill each of those promises.

Not so long ago, we learned of negligence and mismanagement at the VA that left veterans on wait lists for critical health care services for months at a time. Last summer, 1 year after these facts surfaced, we received reports that the wait lists had increased by 50 percent in just 1 year's time, even after the Congress appropriated \$15 billion to reduce the waitlists and hire more caregivers.

To this day, the magnitude of the waitlist problem remains unclear, and the VA inspector general is just now beginning to release the findings of their investigation into the 73 hospitals across the country that forced our veterans to wait for care, care that, in many cases, never came.

You and I both know that treating our veterans with this level of disregard is utterly unacceptable and truly deplorable. Every one on this panel wants to hear more about what you are doing to bring these wait times down and offer our vets the care that they have earned and deserve.

Congress has responded to the challenge by offering veterans the option of accessing care outside of the VA system, through the VA Choice Program. And we need to continue to have a national conversation about the optimal way to match each veteran with the health care provider that will best serve them.

At the same time, we must continue to move forward with initiatives aimed at modernizing and streamlining VA programs and

services. Digitizing VA medical records has been an important focus of you and the Congress, now, for several years. And we have been pressing the department to get this done for some time, now.

Mr. Secretary, you have requested a funding increase for the digitization of VA medical records in your fiscal year 2017 request. The committee appreciates the department's prioritizing of this project this year, and we support your efforts to make the claims process more efficient and reduce the backlog of veterans' claims.

Our veterans seeking access to their rightfully-earned benefits are depending on you and us. Finally, I know you are well aware of the epidemic of prescription drug abuse facing our civilian population and our veterans.

This time last year, we discussed the troubling news that at least one VA hospital had been over-prescribing opioids and contributing to this epidemic that we have been fighting so hard to prevent.

We now know that at least one veteran lost his life because the proper prescribing protocols weren't followed, and the staff on hand was not equipped to intervene. I am pleased to see that the VA Inspector General investigated this unfortunate case, and that the facility is now investing in training programs for its employees, to prevent such a tragedy from recurring.

This committee is interested to know how the department is acting to ensure that this sort of mismanagement and recklessness is not occurring at other hospital facilities and that it never happens again, under our watch.

You have a committed partner in this committee, in the fight against opioid abuse and addiction among our veterans. And we stand ready to provide you with the support you need in this effort.

CDC has said that prescription drug abuse is a national epidemic, that we are losing more people dying of overdoses than car wrecks. And veterans, of course, are not exempt from that phenomenon.

But we do have the facilities, I think, to go a long way toward erasing the problem for veterans. Thank you for being here. I look forward to your answers.

Mr. DENT. Thank you, Mr. Chairman.

And, before we, again, recognize Secretary McDonald, I would like to recognize our distinguished friend and ranking member, the gentlelady from New York, Mrs. Lowey, for her remarks.

FULL COMMITTEE RANKING MEMBER OPENING STATEMENT

Mrs. LOWEY. And I want to thank Chairman Dent and Ranking Member Bishop for holding this very important hearing. And I join my colleagues in welcoming Secretary McDonald and all of our distinguished guests this morning.

This subcommittee must help address the serious challenges facing the Department of Veteran Affairs in delivering to the men and women who have faithfully served our nation the recognition and benefits they deserve.

Mr. Secretary, I thank you for your commitment to bettering the lives of veterans, in particular, your dedication to increasing accountability within your workforce and initiating programs designed to meet the needs of the most vulnerable and at-risk veterans has been an inspiration.

I thank you for your commitment and your efforts to reduce the claims backlog, an issue of great concern to the chairman, to both chairmen, and for everyone on this committee, and, I would say, the entire Congress.

And, although I am pleased the backlog is down considerably from 2 years ago, I know we all know there is a lot more work that we have to do. Yet, as the drawdown of forces in the military continues, I hope the VA will prioritize backlog reductions with the increase of men and women seeking VA care and benefits.

In addition, I am concerned about the health care female veterans receive. Female veterans are one of the fastest growing groups receiving medical care through the VA, yet they still face cultural roadblocks in a system that has traditionally focused on the care of men.

I believe that we need to start a discussion about updating the VA system to better reflect the gender makeup of our armed forces and future veterans.

Mr. Secretary, again, thank you for being here today, for your service to our country. I look forward to hearing your testimony.

Mr. DENT. Thank you, Mrs. Lowey.

At this time, I would like to recognize Secretary McDonald. Please, proceed.

SECRETARY'S OPENING STATEMENT

Secretary McDONALD. Thank you, Chairman Rogers, Chairman Dent, Ranking Member Lowey, Ranking Member Bishop, and members of the subcommittee. Thanks for the opportunity to present the President's 2017 budget and 2018 advanced appropriations request for the Department of Veterans Affairs.

I have submitted a written statement for the record. The President's 2017 budget proposal is another tangible sign of his devotion to veterans and their families. It proposes \$182.3 billion for the department in fiscal year 2017, which includes \$78.7 billion in discretionary funding, a 4.9 percent increase above the 2016 enacted level, largely for health care.

It includes \$65 billion for medical care, a 6.3 percent increase of \$3.9 billion over the 2016 enacted level. It includes \$12.2 billion for care in the community, and a new medical community care budget account to increase transparency on VA's spending for non-VA care, as required in the VA budget and choice improvement act.

It provides \$66.4 billion in advanced appropriations for the VA medical care programs in 2018, a 2.1 percent increase above the 2017 request. It provides \$7.8 billion for mental health. It funds veteran counseling centers, and it funds the Veterans Crisis Line modernization.

This proposal provides \$1.5 billion for effective hepatitis C treatments for, at least, 35,000 veterans, \$1.2 billion for telehealth access, \$725 million for veterans' caregivers, and \$515 million for health programs for women veterans.

The proposal includes \$103.6 billion in mandatory funding for veterans' benefit programs in 2017 and \$103.9 billion in advanced appropriations for our three major mandatory veterans' benefits accounts.

It requests \$2.8 billion for the Veterans Benefits Administration, including support for an additional 300 staff to reduce the non-rating claims inventory and provide veterans with timely decisions on non-rating claims, and includes \$156.1 million for the Board of Veterans Appeals. That is an increase of 42 percent over the 2016 level, as a down-payment on a long-term, sustainable plan to eliminate the appeals backlog.

The budget supports VA's four agency priority goals. It supports our five MyVA transformational objectives, to, first, improve the veteran experience. Second, improve the employee experience. Third, improve internal support services. Fourth, establish a culture of continuous improvement. And, fifth, expand strategic partnerships.

It provides \$2.6 million for the MyVA program office, to help integrate MyVA initiatives across the enterprise, and \$72 million for the Veterans Experience Office, so we can continue establishing high customer service standards.

And it supports our 12 breakthrough priorities for 2016 and into fiscal year 2017. These are critical investments, if we are serious about transforming VA into a high-performing organization veterans deserve and taxpayers expect.

Over three decades in the private sector, I learned firsthand what makes a high-performance organization. And that goal is within our reach. We already have a clear purpose and strong values and sound strategies. We have a growing team of talented business and health care professionals, making innovative changes.

And, you are right, I am the only one at this table who testified last year at the hearing. Ten of our top 16 executives are new, since I became secretary. And we are building responsive systems and processes, shaped by design to meet veterans' needs.

For veterans, that means veterans have 24/7 access to VA systems and know where to get the answers. Veterans calling or visiting primary care facilities in a medical center have clinical needs addressed the very same day.

Veterans engaged in mental health care, needing urgent attention, speak to a provider the same day. And veterans calling for new mental health appointments receive suicide risk assessments and immediate care, if needed.

For employees serving veterans, it means training on advanced business techniques, that drive responsive and innovative change, performance management systems that resonate with employees and encourage continuous improvement and excellence, clear performance expectations, continuous feedback, and employees equipped with the tools to achieve excellence.

It means that executive performance ratings and bonuses reflect actual performance and take into account relevant inputs, like veteran outcomes, employee surveys, and 360-degree feedback. And it means modern, automated systems, in place of antiquated and costly paper processes.

We are advancing along all these lines and many others, growing a high-performing culture at VA is what our Leaders Developing Leaders process is about. We launched Leaders Developing Leaders, or LDL as we call it, last November with 450 senior field leaders.

We have trained more than 5,000 leaders, so far. And we met, again, Monday and Tuesday at our Leesburg, Virginia, national training facility to build on the growing momentum and share best practices that we will leverage across VA.

You see, LDL is a continuous enterprise-wide process to instill lasting change. By year's end, we will have trained over 12,000 senior leaders, empowering more and more teams to dramatically improve veterans care and service delivery.

Private sector leadership experts are teaching VA teams cutting edge business skills, like Lean Six Sigma and Human Centered Design. Human Centered Design and Lean are helping leaders reshape the compensation and pension process that veterans find burdensome.

We are planning to automate performance management to streamline the process and improve rating accuracy. And we are finding new ways to provide higher-quality care and benefits more efficiently.

Our pharmacy benefits management program avoided \$4.2 billion in unnecessary drug expenditures last year. We saved over half a billion dollars in travel spending, since 2013, exceeding goals of the President's campaign to cut waste.

We reduced employee award spending \$150 million and SES bonuses, 64 percent, between 2011 and 2015, by rigorously linking awards to performance. Since 2011, we have saved \$16.6 million using more efficient training and meeting methods.

We are already saving \$10 million a year under our MyVA five-district structure, which we announced in January of 2015. We saved approximately \$5.5 million from 2011 to 2015 by strengthening controls over permanent change of station moves. And we will save millions each year in paper storage, now that we have implemented the electronic claims processing.

So we are committed to doing everything we can for veterans with everything we are given, with more than 100 legislative proposals for meaningful change require Congressional action. Over 40 are new this year, some absolutely critical to maintain our ability to purchase non-VA care.

To best serve veterans, we need your help streamlining VA's care in the community systems and programs. We need your help to modernize and clarify VA's purchased care authorities, to maintain veterans access to timely community care everywhere in the country.

We provided detailed legislation addressing these challenges over 9 months ago. I have consistently identified it as a top legislative priority. Above all, this needs to get done in this Congress, to ensure a strong foundation for success and access to community care.

The budget proposes a simplified, streamlined, and fair appeals process. In 5 years, veterans could have appeals resolved within 1 year of filing. The statutory appeals process is archaic and unresponsive. It is not serving veterans well.

Last year, the board was still adjudicating an appeal that originated 25 years ago and had been decided more than 27 times. Legislating a simplified process can save over \$139 million annually, beginning in 2022.

We compete with the private sector for talent, especially in health care. So we are proposing flexibility on the 80-hour pay period maximum for certain medical professionals. And we are proposing critical compensation reform for network and hospital directors.

Likewise, the Title 38 SES proposal we are working on is about treating VA career executives more like their private sector counterparts. It is private sector flexibility that attracts top performers, and it is not about firing people.

The budget proposes appropriations language for general transfer authority that allows me some measured spending flexibility to respond to veterans' emerging needs. We need Congressional authorization for 18 leases submitted in VA's fiscal year 2015 and 2016 budget requests, as well as authorization for eight major construction projects, included in VA's 2016 request.

We need your support for six additional replacement major medical facility leases in the 2017 budget. And passing special legislation for VA's West Los Angeles campus will produce positive results for veterans there, who are most in need.

This Congress, with today's VA leadership team, can make these changes, and more, for veterans. Then we can look back on this year as the year that we turned the corner. I appreciate this opportunity and the support you have shown veterans, the department, and the MyVA transformation. And I look forward to your questions.

Thank you.

[The information follows:]

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

**FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS,
AND RELATED AGENCIES**

**BUDGET REQUEST FOR FISCAL YEAR 2017
MARCH 2, 2016**

Good morning, Chairman Dent, Ranking Member Bishop, and Distinguished Members of the House Appropriations Subcommittee on Military Construction and Veterans Affairs. Thank you for the opportunity to present the President's 2017 Budget and 2018 Advance Appropriations (AA) requests for the Department of Veterans Affairs (VA). This budget continues the President's faithful support of Veterans and their families and survivors, and it sustains VA's historic transformation. It will provide the funding needed to enhance services to Veterans in the short term, while strengthening the transformation of VA that will better serve Veterans in the future.

A Vision for the Future

VA's vision for the future is to be the No. 1 customer-service agency in the Federal government. The American Customer Satisfaction Index already rates our National Cemetery Administration No. 1 with respect to customer service. In addition, for the sixth year in a row, VA's Consolidated Mail Outpatient Pharmacy received J.D. Power's highest customer satisfaction score among the Nation's public and private mail-order pharmacies. These are compelling examples of excellence. We aim to make that so for all of VA.

We are transforming the entire Department, not just making incremental changes to parts of it. We began in July 2014 by immediately reinforcing the importance of our inspiring mission—caring for those “who shall have borne the battle,” their families, and their survivors. Then, we re-emphasized our commitment to our exceptional I-CARE Values—Integrity, Commitment, Advocacy, Respect, and Excellence. To provide timely quality care and benefits for Veterans, everything we are doing is built, and must be built, on the rock-solid foundation of mission and values.

MyVA is the catalyst making VA a world-class service provider. It is a framework for modernizing VA's culture, processes, and capabilities so we put the needs, expectations, and interests of Veterans and their families first, and put Veterans in control of how, when, and where *they* wish to be served.

Listening to others' perspectives and insights has been, and remains, instrumental in shaping our transformation. We have taken advantage of an unprecedented level of outreach to the field and our stakeholders. In my first months as Secretary, I assessed VA and recognized that we would need to change fundamental

aspects of every part of VA in order to rise to excellence. I shared my assessment's results with President Obama and received his guidance. I discussed my findings with you and other Members of Congress—privately and during hearings. And I consulted with literally thousands of Veterans, VA clinicians, VA employees, and Veteran Service Organizations (VSOs) and other stakeholders in dozens of meetings.

Since my July 29, 2014, confirmation, I have made 277 visits to VA field sites in more than 100 cities, including 47 visits to VA Medical Centers, 30 visits to homeless Veterans program sites, 16 visits to Community Based Outpatient Clinics, 15 Regional Offices, and 9 Cemeteries. I have attended 61 Veteran engagements through public and private partnerships and 60 stakeholder events to hear firsthand the problems and concerns impacting our Veterans. To recruit individuals to work for VA as medical professionals and in other critical fields, I have visited 50 medical schools, universities, and other educational institutions. This kind of outreach, partnership, and collaboration underpins our department-wide transformation to change VA's culture and make the Veteran the center of everything we do.

Progress

Transforming an organization of VA's size is an enormous undertaking. It will not happen overnight. But we are now running the government's second largest Department like a \$166 billion Fortune 6 organization should be run. That is, balancing near term performance improvements while rebuilding VA's long-term organizational health.

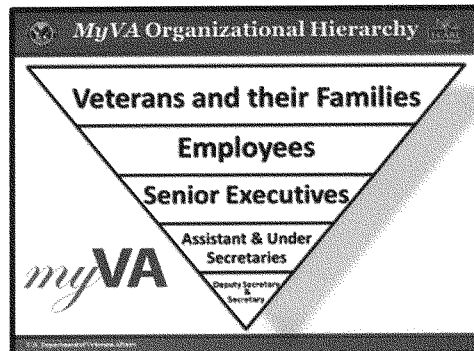
Effective change often requires new leadership, and we have made broad changes. Of our top 16 executives, 10 are new to their positions since I became Secretary. Our team today includes extensive executive expertise from the private sector: a former banking industry Chief Financial Officer and President of the USO; the former Chief Executive Officer of Beth Israel Medical Center in New York City and Morristown Medical Center in New Jersey; a former Chief Executive of Jollibee Foods and President of McDonald's Europe; a former Chief Information Officer of Johnson & Johnson and Dell Inc.; a former partner in McKinsey & Company's Transformational Change and Operations Transformation Practices; a retired partner in Accenture's Federal Services Practice; a former Chief Customer Officer for the City of Philadelphia who previously spent 10 years at United Services Association of America (USAA), one of the best and foremost customer-service organizations in the country; a former entrepreneur and CEO of multiple technology companies; and a retired Disney executive who spent 2010-2011 at Walter Reed National Military Medical Center enhancing the patient experience.

Most members of the executive leadership team are Veterans themselves. They have served from Vietnam to Iraq and Afghanistan, and each is here because he or she demonstrates a personal commitment to our mission. These fresh, diverse perspectives, combined with our more experienced government and health care executives, will continue to catalyze innovation and change.

Thanks to the continuing support of Congress, VSOs, union leaders, our dedicated employees, states, and private industry partners, we have made tremendous headway over the past 18 months. In 2015, we made notable progress building the momentum that will begin delivering transformational changes that VA needs.

Congress has passed key legislation—such as the Veterans Access, Choice, and Accountability Act and the Clay Hunt Suicide Prevention for American Veterans Act—that gives VA more flexibility to improve our culture and ability to execute effectively.

Consistent with the culture of a High Performance Organization that serves Veterans and their families, we have turned VA's structural pyramid upside down. Veterans and their families are at the top. The Office of the Secretary is at the bottom, *supporting* subordinate leaders and the workforce who are serving Veterans. This method of thinking and operating is a reminder to all employees and stakeholders that we are here to support our Veterans, not our bosses.



While reinforcing our I-CARE Values, we are transitioning from a rules-based culture that may neglect the human dimension of service to a principles-based culture grounded in values, sound judgment, and the courage and opportunity "to choose the harder right instead of the easier wrong"

We formed a MyVA Advisory Committee (MVAC) to advise us on our transformation. The MVAC is comprised of a diverse group of business leaders, medical professionals, experienced government executives, and Veteran advocates. The Chairman is retired Major General Joe Robles, former Chairman and CEO of USAA. The Vice Chairman is Dr. J. Michael Haynie, Air Force Veteran, Vice Chancellor of Syracuse University and founder of the Institute for Veteran and Military Families (IVMF). The MVAC includes executives with deep customer service and transformation expertise from organizations such as Amazon, The Cleveland Clinic, McKinsey & Company, Johns Hopkins, Mayo Clinic, as well as a former Surgeon General, a former White House doctor for three US Presidents, a university president who was a Rhodes Scholar from the Air Force Academy who currently serves as a reserve Air Force Lieutenant Colonel, and advocates for both the traditional VSOs and post-9/11 Veterans' organizations.

Private sector leadership experts are bringing cutting-edge business skills and developing VA teams in new ways. We are training critical pockets of our workforce on advanced techniques like Lean and Human Centered Design. For example, working with the University of Michigan, we have already trained more than 5,000 senior leaders across the Nation in our "Leaders Developing Leaders." The Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), and our Veterans Experience team collaborated using Human Centered Design and Lean techniques to redesign the Compensation and Pension Examination (C&P Exam) process because we received consistent feedback that the process—often, a Veteran's first impression of the VA when separating from service—can be a confusing and uncomfortable experience.

Across VA, we are encouraging different perspectives and listening to all of our key stakeholders, even those who are critical of VA. To benchmark and capture ideas and best practices along our transformation journey, we have been working collaboratively with world-class institutions like Procter & Gamble, USAA, Cleveland Clinic, Wegmans, Starbucks, Disney, Marriott and Ritz-Carlton, NASA, Kaiser Permanente, Hospital Corporation of America, Virginia Mason, DoD, and GSA, among others.



VA named the Department's first Chief Veteran Experience Officer and began staffing the office that will work with the field to establish customer service standards, spread best practices, and train our employees on advanced business skills.

Rather than asking Veterans to navigate our complicated internal structure, we are redesigning functions and processes to fit Veteran needs in the spirit of General Omar Bradley's 1947 proposition that "We are dealing with Veterans, not procedures; with their problems, not ours."

We are realigning VA to facilitate internal coordination and collaboration among business lines—from nine disjointed, disparate organizational boundaries and organizational structures to a single framework. That means down-sizing from 21 service networks to 18 that are aligned in five districts and defined by state boundaries, except in California. This realignment means opportunities for local level integration, and it promotes consistently effective customer service. Veterans from Florida to

California, Puerto Rico to Maine, Alaska and Guam, and all parts in between, will see one VA.

We have developed a multi-year plan for creating a world-class Information Technology organization, and on November 11, Veterans Day, we launched the Vets.gov initial capability. Developed with support from the U.S. Digital Services Team and informed by extensive feedback from Veterans, Vets.gov is a modern, mobile-first, cloud-based website that will replace numerous other websites and website logins with a single, easy to navigate location. The website puts Veteran needs and wishes first, and we will continue to add the capability that's required to improve its accessibility and usefulness. As Vets.gov evolves, it will simplify the Veteran experience by re-using and making consistent Veteran information, including mailing address and phone number, across the agency.

At VA, we know that serving Veterans is a collaborative exercise, so we will not function in a vacuum. We are operating as part of a community of care, forming strategic partnerships with external organizations to leverage the goodwill, resources, and expertise of valuable partners to better serve our Nation's Veterans and help address a wide variety of Veteran needs, including employment, homelessness, wellness, and mental health. Partners include respected organizations like the YMCA, the Elks, the PenFed Foundation, LinkedIn, Coursera, Google, Walgreens, academic institutions, other Federal agencies, and many more. These partnerships reflect our commitment to re-thinking how VA does business so we can leverage the strengths of others who also care for Veterans.

We have enabled 39 Community Veterans Engagement Boards, a national network designed to leverage *all* community assets, not just VA assets, to meet local Veteran needs. Sixteen more communities are in development right now.

We have renewed and redefined working relationships with our union partners, and union leaders are part of the team, and have had significant input into MyVA. We continue to work with them to address issues and make sure our employees are involved often and early in every major decision.



We are continuing to develop a robust provider network while we streamline business processes and re-imagine how we obtain services such as billing, reimbursement credentialing, and information sharing.

We continue to listen, learn, and grow.

VA's Agency Priority Goals

In 2015, we were guided by and made notable progress toward reaching our three Agency Priority Goals (APGs)—(1) Improve Veteran Access to VA Benefits and Services, (2) End Veteran Homelessness, and (3) Eliminate the Disability Claims Backlog. These accomplishments toward achieving our APGs demonstrate VA's commitment to using our resources effectively to improve care and benefits for Veterans.

Access

We expanded capacity by focusing on staffing, space, productivity, and VA Community Care.

Since discovering the access challenges in Phoenix, Arizona, we have aggressively improved access to care, not just in Phoenix but across VA as a whole. For instance, in the first 12 months after discovering the Phoenix appointment problem, from June 2014 to June 2015, we completed 7 million more appointments than during the same period the year prior: 2.5 million of those appointments were at VA; 4.5 million appointments were in the community. Altogether in FY 2015, we completed 56.7 million appointments, nearly 2 million more than in FY 2014. More than 97 percent (55 million) of those 56.7 million appointments were completed within 30 days of the clinically indicated or Veteran's preferred date, an increase of 1.4 million over the FY 2014 numbers.

Veteran access is one of the five critical priorities supporting VA health care transformation with far-reaching impact across VA that Under Secretary for Health, Dr. David J. Shulkin announced in September 2015. With the Access Stand Downs, VHA is empowering each facility to focus on the needs of its specific population and refocusing people, tools, and systems on a journey of continuous improvement towards same-day access for primary care and urgent specialty care. The immediate goal is that no patients with urgent appointment requests in VA clinics with the most critical clinical needs, such as cardiology, urology, and mental health, are waiting more than 30 days.

From November 9, through November 13, 2015, VHA conducted a complete review of all Veterans waiting for appointments—with a focus on those Veterans waiting for clinically important and acute services—to ensure that the wait was clinically appropriate as determined by the Veteran's treatment team. This process culminated with the VHA's first-ever Access Stand Down on November 14th. The Stand Down was a nationwide effort to ensure Veterans get the right care at the right time.

In the first Access Stand Down, VHA reviewed nearly 55,800 of the more than 56,000 urgent consults that remained open more than 30 days (as of November 6,

2015), a herculean effort. Of those 55,800 urgent open consults reviewed, 82 percent (45,849) were scheduled or closed by the end of that first Stand Down.

Building on the November 14th Access Stand Down momentum and success, VHA continued to maximize accessibility to outpatient services with the February 27th, 2016 Access Stand Down. The February Stand Down provided an opportunity to make another significant leap in dramatically enhancing Veterans' access to care. Clinical operations will meet customer demand through resource-neutral, continuous improvement at the facility-level and scaling-up excellence across the enterprise.

VetLink data is another way we are listening to Veterans. Since September 2015, VHA has analyzed preliminary data from VetLink, our kiosk-based software that allows us to collect real-time customer satisfaction information. In all three separate VetLink surveys to date—related to nearly half-a-million appointments—Veterans told us that about 90 percent of the time, they are either “completely satisfied” or “satisfied” with getting the appointment when they wanted it. However, about 3 percent of Veterans who participated in the survey were either “dissatisfied” or “completely dissatisfied,” so we have more work to do.

Staffing. We increased net VHA staffing. In FY 2015, VHA hired 41,113 employees, for a net increase of 13,940 health care staff, a 4.7 percent increase overall. That increase included 1,337 physicians and 3,612 nurses, and we filled several critical leadership positions, including the Under Secretary of Health.

Space. We activated an additional 2.2 million square feet of clinical space in FY 2015, adding to the more than 1.7 million square feet of clinical space activated in FY 2014.

Productivity. We increased physician work Relative Value Units (RVUs) by 9 percent from FY 2014 to FY 2015. VA completed more than 1.4 million extended hour completed encounters in primary care, mental health and specialty care in FY 2014 and more than 1.5 million in FY 2015, an increase of 5.7 percent in extended hour encounters.

Care in the Community

In 2015, VA obligated \$10.5 billion for Veterans Care in the Community, including resources provided through the Veterans Choice Act—an increase of \$2.3 billion (28 percent) over the 2014 level—which resulted in nearly 2.4 million authorizations for Veterans to receive Care in the Community from December 3, 2014 through December 2, 2015. Programmatically, this included care in the community for Veterans' dialysis, state home programs, community nursing care, Veterans home programs, emergency care, private medical facilities care, and care delivered at Indian health clinics. It also includes care under VA's CHAMPVA program for certain dependents entitled to that care.

Homelessness

Veteran homelessness has continued to decline, thanks in large part to unprecedented partnerships and vital networks of collaborative relationships across the Federal government, across state and local government, and with both non-profit and for-profit organizations. Ending and preventing Veteran homelessness is now becoming a reality in many communities, including: the Commonwealth of Virginia; the State of Connecticut; New Orleans, Louisiana; Houston, Texas; Las Vegas, Nevada; Philadelphia, Pennsylvania; Syracuse, New York; Winston-Salem, North Carolina; and Las Cruces, New Mexico. In collaboration with our Federal and local partners, we have greatly increased access to permanent housing; a full range of health care including primary care, specialty care, and mental health care; employment; and benefits for homeless and at-risk for homeless Veterans and their families.

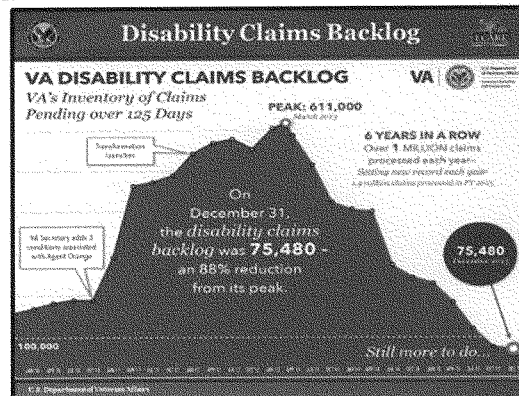
In FY 2015 alone, VA provided services to more than 365,000 homeless or at-risk Veterans in VHA's homeless programs. Nearly 65,000 Veterans obtained permanent housing through VHA Homeless Programs interventions, and more than 36,000 Veterans and their family members, including 6,555 children, were prevented from becoming homeless.

Overall Veteran homelessness dropped by 36 percent between 2010 and 2015, based on data collected during the annual Point-in-Time (PIT) Count conducted on a single night in January 2015. We saw a nearly 50 percent drop in unsheltered Veteran homelessness. Since 2010, more than 360,000 Veterans and their family members have been permanently housed, rapidly rehoused, or prevented from falling into homelessness.

Disability Claims Backlog

VA transitioned disability compensation claims processing from a paper-intensive process to a fully electronic processing system; as a result, 5,000 tons of paper per year were eliminated.

In FY 2015, VA decided a record-breaking 1.4 million disability compensation and pension (rating) claims for Veterans and their survivors—the highest in VA history for a single year. As of December 31, 2015, VA had driven down the disability claims backlog to 75,480, from a peak of over 611,000 in March 2013.



2016-2017 VA's Agency Priority Goals

In a collaborative, analytical process, VA has established our four new Agency Priority Goals (APGs). In FYs 2016 and 2017, our four APGs build upon and preserve progress we made in 2015. The new APGs will help accelerate the MyVA transformation and advance our framework for allocating resources to improve Veteran outcomes. Our new APGs are to (1) Improve Veterans Experience with VA, (2) Improve VA Employee Experience, (3) Improve Access to Health Care as Experienced by the Veteran, and (4) Improve Dependency Claims Processing. While no longer APGs, VA will continue to build upon the progress it has already made related to increasing access to care and services, ending Veterans' Homelessness and eliminating the compensation rating claims backlog.

FY 2017 Budget Request

Our 2017 budget requests the necessary resources to allow us to serve the growing number of Veterans who selflessly served our Nation.

The 2017 Budget requests \$182.3 billion for VA—\$78.7 billion in discretionary funding (including medical care collections) and \$103.6 billion in mandatory funding for Veterans benefit programs. The discretionary request reflects an increase of \$3.6 billion (4.9 percent) over the 2016 enacted level. The budget also requests 2018 advance appropriations (AAs) of \$66.4 billion for Medical Care and \$103.9 billion for three mandatory accounts that support Veterans benefit payments (i.e., Compensation and Pensions, Readjustment Benefits, and Insurance and Indemnities).

We value the support that Congress has demonstrated in providing the resources needed to honor our Nation's Veterans. We are seeking your support for legislative proposals contained in the 2017 Budget—including many already awaiting Congressional action—to enhance our ability to provide Veterans the benefits and services they have earned through their service. The Budget also proposes appropriations language to provide a new General Transfer Authority that would allow VA to move discretionary funds across line items. Flexible budget authority would give VA greater ability to avoid artificial restrictions that impede our delivery of care and benefits to Veterans.

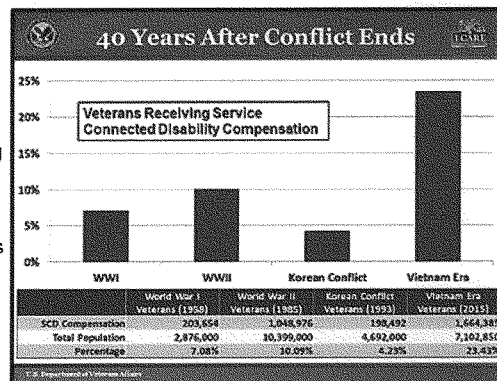
Rising Demand for VA Care and Benefits

Veterans are demanding more services from VA than ever before. As VA becomes more productive, the demand for benefits and services from Veterans of all eras continues to increase, and Veterans' demand for benefits has exceeded VA's capacity to meet it.

In 2014, when the Phoenix access difficulties came to light, VA had 300,000 appointments that could not be completed within 30 days of the date the Veteran needed or wanted to be seen. To meet that demand, VA rallied to add capacity to complete 300,000 more appointments each month, or about 3.5 million additional appointments annually.

Despite these extraordinary measures to increase capacity, VA was unable to absorb Veterans' increasing demand for health care. The number of Veterans waiting for appointments more than 30 days rose by about 50 percent, to roughly 450,000 between 2014 and 2015, so we are aggressively working on innovative ways to address that challenge, and VHA's new Access Stand Downs are central to VHA's healthcare transformation efforts and addressing that challenge.

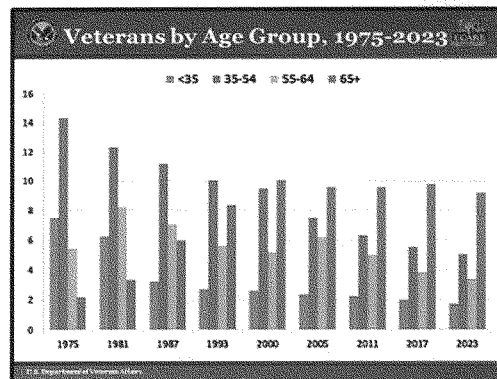
The trend of a growing demand for VA health care is fueled by more than a decade of war, Agent Orange-related disability claims, an unlimited claim appeal process, demographic shifts, increased medical issues claimed, and other factors. Additionally, survival rates among Americans who served in conflicts have increased, and more sophisticated methods for identifying and treating Veteran medical issues continue to become available. And, VA now serves a population that is older, has more chronic conditions, and is less able to afford care in the private sector. Workload will continue to increase as the military downsizes and Veterans regain trust in VA.



In 2017, the number of Veterans receiving medical care at VA will be over 6 million. VA expects to provide more than 115 million outpatient visits in 2017, an increase of 8.4 million visits over 2016, through both VA and Care in the Community.

Compared to FY 2009, the number of patients is projected to increase by 22 percent by FY 2017. And, as Veterans see the results of VA's transformation, we are confident that the number of Veterans utilizing VA services will continue to rise. Currently, 11 million of the 22 million Veterans in this country are registered, enrolled, or use at least one VA benefit or service.

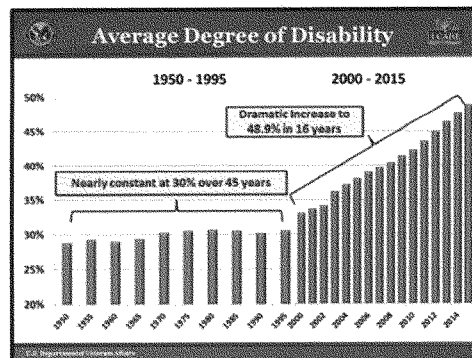
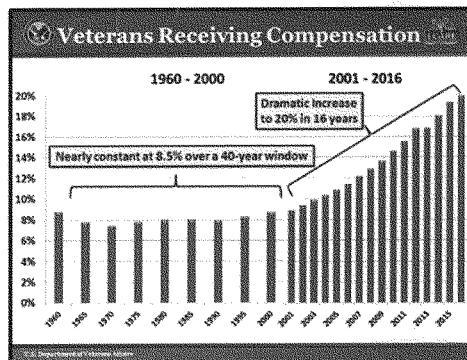
Veterans' health care and benefit requirements continue to increase decades after conflicts end, and this fact is a fundamental, long-term challenge for VA. Forty years after the Vietnam War ended, the number of Vietnam Era



Veterans receiving disability compensation has not yet peaked. VA anticipates a similar trend for Gulf War Era Veterans, only 26 percent of whom have been awarded disability compensation.

Today, there are an estimated 22 million Veterans. The number of Veterans is projected to decline to around 15 million by 2040. However, while the absolute number may decline, an aging Veteran population requires greater care, services, and benefits. In 2017, 46 percent (or 9.8 million) of the 22 million Veteran population will be 65 years old or older, a dramatic increase since 1975, when only 7.5 percent (or 2.2 million) of the Veteran population was 65 years old or older.

While the percent of the Veteran population receiving compensation was nearly constant at 8.5 percent for more than 40 years, over the past 15 years there has been a striking increase to 20 percent. The total number of service-connected disabilities for Veterans receiving compensation grew from 11.8 million in 2009 to 19.7 million in 2015, an increase of more than 67 percent in just six years. This dramatic growth, combined with estimates based on historic trends, predicts an even greater increase in claims for more benefits as Veterans age and disabilities become more acute.



The increase in Veterans receiving compensation is accompanied by a significant increase in the average degree of disability granted to Veterans for disability compensation. For 45 years, from 1950 to 1995, the average degree of disability held steady at 30 percent. But, since 2000, the average degree of disability has risen to 49 percent. VBA's mandatory request for 2017 is \$103.6 billion, twice the amount spent in FY 2009.

As VA continues to improve access and quality of care, more Veterans will come to VA for more of their care. Veterans today often choose VA for care either because of personal preference or because of VA's economic edge. Some 78 percent of enrolled Veterans at VA have

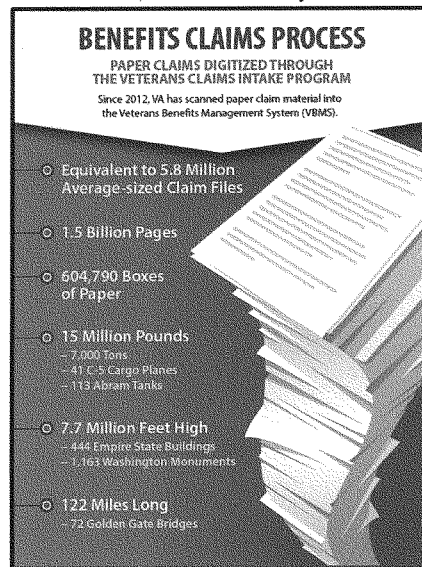
other choices like Medicare, Medicaid, Tricare, or private insurance. Out-of-pocket cost for Veterans at VA is often lower, and cost considerations are a key factor in Veterans' demand for VA health care. In 2014, Veteran enrollees received only 34 percent of their total health care through VA, accounting for about \$53 billion in 2014 costs. Just a one percent increase in Veteran reliance on VA health care will increase costs by \$1.4 billion.

Productivity Improvements and Stewardship

The MyVA transformation will ensure VA is a sound steward of the taxpayer dollar. We are instituting operational efficiencies, cost savings, productivity improvements, and service innovations to support this and future budget requests. We are assessing all aspects of VA operations using a business lens and pursuing changes so VA will deliver care and services more efficiently and effectively at the highest value to Veterans and taxpayers. For instance, few realize that when it comes to the general operating expense of distributing over a hundred-billion dollars in benefits to over 5.3 million Veterans and survivors, VBA spends only about 3 cents on the dollar. By any measure, that's an excellent return on investment. Our Reports, Approvals, Meetings, Measurements, and Policies (RAMMPs) process identifies practices to streamline or, in some cases, eliminate entirely. To free capacity and empower employees to identify counter-productive or wasteful activities that management can eliminate, VA

leaders at all levels of the organization are using RAMMP to address opportunities for improvement that employees have identified.

To boost efficiency and employee productivity, VA is quickly moving to paperless claims processing from its historically manual, paper-intensive process. Modernizing to an electronic claims processing system has helped VBA increase claim productivity per claims processor by 25 percent since 2011 and medical issue productivity by 82 percent per claims processor since 2009. This significant productivity increase helped mitigate the effects of the 131 percent increase in workload between 2009 and 2015, when the number of medical issues rose from 2.7 million to 6.4 million. VA's shift to electronic claims processing has meant converting paper files to eFolders.



Between 2012 and 2015, the Veterans Claims Intake Program (VCIP) scanned nearly 6 million claims files into Veterans' eFolders in the Veterans Benefits Management

System (VBMS). VBA has removed more than 7,000 tons of claims-related papers formerly undermining efficiency, hampering productivity, and cluttering workspace.

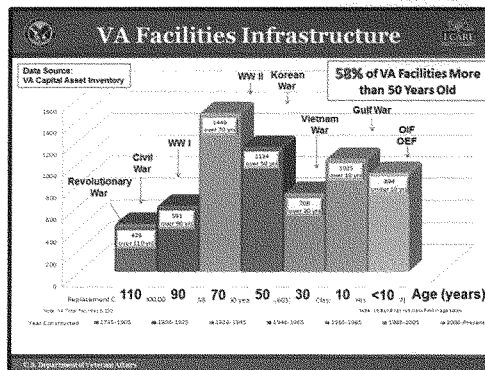
In FY 2015, VBA deployed its innovative Centralized Mail Initiative to 56 regional offices (ROs) and one pension management center (PMC). Centralized Mail reroutes inbound compensation and pension claims-related mail directly to Claims and Evidence Intake Centers at document conversion services vendor sites, an innovation that improves productivity and enabled digital analysis of more than four million mail packets. Through Centralized Mail, VBA can more efficiently manage the claims workload, and prioritize and distribute claims electronically across the entire RO network, maximizing resources and improving processing timeliness.

To strengthen financial management and stewardship, in FY 2015 VA launched its multi-year effort to replace VA's antiquated, 30-year-old core Financial Management System (FMS) with a 21st century system that will vastly improve VA financial management accuracy and transparency. The modernization effort requires robust enterprise-wide support across the Department. In FY 2015, VA committed to using a shared service solution and engaged the Department of Treasury's Office of Financial Innovation and Transformation (FIT) to pursue a Federal Shared Service Provider that leverages existing, successful investments and infrastructure across the government and meets our financial management system needs while supporting VA's mission of serving Veterans. VA also stood up a Program Management Office, initially staffed with 5 FTE from existing resources to lead and manage the effort, and identified an OIT Project Manager. VA has worked to compile lessons-learned from other agencies engaged in this effort and from VA's previous attempts to modernize the FMS, to ensure the effort is successful. Tasks ahead include strategies, roadmaps, and project plans, business process re-engineering, and engaging in significant change management activities.

Recent challenges managing non-VA care program finances have demonstrated the great risks and immense burden of the FMS legacy system. FMS failure would severely impede the Department's ability to execute its budget, pay vendors and Veterans, and produce accurate financial statements.

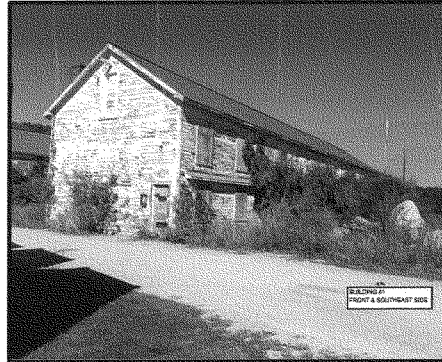
Closing Unsustainable Facilities

It is well-past time to close VA's old, substandard, and underutilized facilities. VA's 2016 Budget testimony last year explained that VA cannot be a sound steward of taxpayer resources with the asset portfolio it carries, and each year of delay makes the situation more costly and untenable. No sound business would carry such a portfolio, and



Veterans and taxpayers deserve better.

VA currently has 370 buildings that are fully vacant or less than 50 percent occupied, which are in excess to our needs. These vacant buildings account for over 5.2 million square feet of unneeded space. In addition, we have 770 buildings that are underutilized, accounting for more than 6.3 million square feet that are candidates to be consolidated to improve utilization and lower costs. This means we have to maintain over 1,100 buildings and 11.5 million square feet of space that is unneeded or underutilized – taking funding from needed Veteran services. We estimate that it costs VA \$26 million annually to maintain and operate these vacant and underutilized buildings. For example, when attempting to demolish the vacant storage facility in Bedford, Massachusetts, VA encountered environmental issues that prevented the demolition, forcing VA to either pay costly remediation costs to demolish a building we no longer need or maintain facilities such as this across the system.



**Bedford, Massachusetts –
Vacant Storage Building, built in 1939**

As the Veteran population has migrated, VA's capital infrastructure has not kept pace. We continue to operate medical facilities where the Veteran population is small or shrinking. Our smallest hospitals often do not have sufficient patient volume and complexity of care requirements to maintain the clinical skills and competencies of physicians and nurses.

Ensuring Veterans Access to Care

The President's 2017 Budget will allow VA to operate the largest integrated health care system in the country, including nearly 1,300 VA sites of health care and approximately 6 million Veterans receiving care; the eleventh largest life insurance provider, covering both active duty Servicemembers and enrolled Veterans; compensation and pension benefit programs serving more than 5.3 million Veterans and survivors; education benefits to more than one million students; vocational rehabilitation and employment benefits to more than 140,000 disabled Veterans; a home mortgage program that will guarantee more than 429,000 new home loans; and the largest national cemetery system that leads the industry as a high-performing organization, with projections to inter more than 132,000 Veterans and family members in 2017.

The 2017 Budget requests \$65 billion for medical care, an increase of \$3.9 billion (6.3 percent) over the 2016 enacted level. The increase in 2017 is driven by Veterans'

demand for VA health care as a result of demographic factors, economic assumptions, investments in access, and high priority investments for caregivers, new Hepatitis C treatments, and support for Veterans Care in the Community. The 2017 request supports programs to end and prevent Veteran homelessness, invests in strategic initiatives to improve the quality and accessibility of VA health care programs, continues implementation of the Caregivers and Veterans Omnibus Health Services Act, and provides for activation requirements for new or replacement medical facilities. The 2017 appropriations request includes an additional \$1.7 billion above the enacted 2017 AA for Veterans medical care. The request assumes approximately \$3.6 billion annually in medical collections in 2017 and 2018. For the 2018 Advance Appropriations for medical care, the current request is \$66.4 billion.

Hepatitis C Treatment

Although the Hepatitis C virus infection (HCV) takes years to progress, it is the main cause of advanced liver disease in the United States. Treatment of this disease remains a high priority because its cure dramatically lowers patients' risk of liver failure, liver cancer, and death.

VA is the largest single provider of care in the Nation for chronic HCV, and over the next five years, VA will strive to provide treatment to all Veterans with HCV who are treatment candidates. For FY 2017, VA is requesting \$1.5 billion for the cost of Hepatitis C drugs and clinical resources. With a budget of \$1.5 billion in FY 2017, VA expects to treat at least 35,000 patients with HCV; the actual number of patients treated will depend on the cost to VA of Hepatitis C drugs. At the beginning of FY 2016, almost 120,000 Veterans in VA care were awaiting HCV treatment, of whom approximately 30,000 have advanced liver disease.

VA successfully negotiated extremely favorable pricing for both of the new treatments available—Harvoni and Viekira—from two different drug manufacturers by stressing VA's proven ability to deliver market share, VA's large HCV population, and the long-term impact that VA's physician residency programs can have on post-residency prescribing practices.

During FY 2015, VA medical facilities treated more than 30,000 Veterans for HCV with these new drugs with remarkable success, achieving cure rates of 90 percent, similar to those seen in clinical trials.

VA clinicians have rapidly adopted new, more effective therapies for HCV as they have become available. New therapies are costly and require well-trained clinical providers and support staff, presenting resource challenges for the Department. VA will focus resources on the sickest patients and most complex cases and continue to build capacity for treatment through clinician training and use of telehealth platforms. Patients with less advanced disease are being offered treatment through the Veterans Choice program in partnership with community HCV providers.

Care in the Community

VA is committed to providing Veterans access to timely, high-quality health care. The 2017 Budget includes \$12.2 billion for Care in the Community and includes a new Medical Community Care budget account, consistent with the VA Budget and Choice Improvement Act (P.L. 114-41). Of the total that will be spent on non-VA care in FY 2017, \$7.5 billion will be provided through a transfer of the 2017 enacted AA from the Medical Services account to the new budget account, and \$4.7 billion will be provided through the resources provided in the Veterans Choice Act for implementation of the Veterans Choice Program.

The Choice Act increased VA's in-house capacity by funding medical personnel growth in VA facilities and expanded eligibility for Care in the Community to ensure access to care within 30 days and to provide care closer to home for enrollees residing more than 40 miles from a VA facility (the 40-mile group).

This additional capacity facilitated an increase in enrollees' reliance on VA health care by more than half a percent over the level expected in FY 2015. This growth was the result of enrollees increasing their use of VA funded health care versus their use of other health care options (Medicare, Medicaid, commercial insurance, etc.).

The FY 2015 growth in enrollee reliance was largely in Care in the Community, with the 40-mile group generating a more significant increase in care:

- In FY 2015, enrollees' reliance on VA health care increased by 0.7 percent overall. Reliance for the 40-mile group increased by 2.8 percentage points from 32.5 percent to 35.3 percent.
- The increase in reliance was mostly driven by growth in Care in the Community. Cost sharing levels in VA are lower than what is typically available elsewhere, which provides an incentive for enrollees to use VA-paid Care in the Community.

Enrollee reliance on VA health care is expected to continue to increase in 2016 and beyond to service the unmet demand that the Choice Act was enacted to address.

On October 30, 2015, VA provided Congress with a plan for the consolidation and improvement of all purchased care programs into one New Veterans Choice Program (New VCP). Consistent with this report, the 2017 Budget includes legislative proposals to streamline and improve VA's delivery of Community Care.

Caregiver Support Program

Caregivers give their time and love in countless behind-the-scenes ways. Whether they are helping with transportation to and from appointments, helping the Veteran apply for benefits, or helping with meals, bathing, clothing, medication, the spectrum of care is wide and compassion runs deep.

The 2017 Budget requests \$725 million for the National Caregivers Support Program to support nearly 36,600 caregivers, up from about 30,600 in FY 2016.

Funding requirements for caregivers are driven by an increase in the eligible Veteran population, with caregiver enrollment increasing by an average of about 500 each month.

Ending Veteran Homelessness

The ambitious goal of ending Veteran homelessness has galvanized the Federal government and local communities to work together to solve this important National problem. Our systems are designed to help prevent homelessness whenever possible, and our goal is a systematic end to homelessness, meaning that there are no Veterans sleeping on our streets and every Veteran has access to permanent housing. Should Veterans become homeless or be at-risk of *becoming* homeless, there will be capacity to quickly connect them to the help they need to achieve housing stability.

The 2017 Budget supports VA's commitment to ending Veteran homelessness by emphasizing rescue for those who are homeless today and prevention for those at risk of homelessness. The 2017 Budget requests \$1.6 billion for VA homeless-related programs, including case management support for the Department of Housing and Urban Development (HUD)-VA Supportive Housing program (HUD-VASH), the Grant and Per Diem Program, VA justice programs, and the Supportive Services for Veteran Families program.

In FY 2015 and FY 2016, VA committed more than \$1.5 billion annually to strengthen programs that prevent and end homelessness among Veterans. Communities that have reached the goal or are close to effectively ending homelessness rely heavily on VA targeted homeless resources. Communities that have a sustainment plan are depending on those resources to be available as they continue to tackle homelessness and sustain the support for Veterans who have moved into permanent housing, ensuring that they maintain housing stability and do not fall back into homelessness.

VA will continue to advocate for its continuum of homeless services to address the needs associated with preventing first-time homelessness, as well as the needs of those who return to homelessness, and focus on the root causes associated with homelessness, including poverty, addiction, mental health, and disability.

Congress has an important role, as well, in ensuring adequate resources to meet the needs of those most vulnerable Veterans by enacting authorizations and other legislation to provide VA with a full complement of tools to combat homelessness—including legislation that is a prerequisite to carry out dramatic improvements to our West Los Angeles campus centered on the needs of Veterans.

Benefits Programs

The 2017 Budget requests \$2.8 billion and 22,171 FTE for VBA General Operating Expenses, an increase of \$93.4 million (3.4 percent) over the 2016 enacted level. The request includes an additional 300 full-time equivalent (FTE) employees for non-rating claims.

With the resources requested in the 2017 Budget, VA will provide:

- Disability compensation and pension benefits for 5.3 million Veterans and survivors, totaling \$86 billion;
- Vocational rehabilitation and employment benefits to nearly 141 thousand disabled Veterans, totaling \$1.4 billion;
- Education benefits totaling \$14 billion to more than one million Veterans and family members;
- Guaranty of more than 429,000 new home loans; and
- Life insurance coverage to 1.0 million Veterans, 2.2 million Servicemembers, and 2.8 million family members.

Improving the quality and timeliness of disability claim decisions has been integral to VBA's transformation of benefits delivery. VBA successfully streamlined a complex and paper-bound compensation claims process and implemented people, process, and technology initiatives necessary to optimize productivity and efficiency. In alignment with the MyVA transformation, VBA is working to further improve its operations with a focus on the customer experience. We are implementing enhancements to enable integration across our programs and organizational components, both inside and outside of VBA.

VBA has processed an unprecedented number of rating claims in recent fiscal years (nearly 1.4 million in 2015, and more than 1 million per year for the last 6 years). However, its success has resulted in other unmet workload demands. As VBA continues to receive and complete more disability rating claims, the volume of non-rating claims, appeals, and fiduciary field examinations increases correspondingly.

- **Non-rating claims.** VA completed nearly 37 percent more non-rating work in 2015 than 2013—and 15 percent more than 2014. The 2017 Budget requests \$29.1 million for an additional 300 non-rating claims processors to reduce the non-rating claims inventory and provide Veterans with more timely decisions on non-rating claims.
- **Appeals.** Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA continues to receive and complete record-breaking numbers of disability rating claims, the volume of appeals correspondingly increases. As of December 31, 2015, there were more than 440,000 benefits-related appeals pending in the Department at various stages in the multi-step appeals process, which divides responsibility between VBA and the Board of Veterans' Appeals (Board)—355,803 of those benefits-related appeals are in VBA's jurisdiction and 85,682 are within the Board's jurisdiction.

Under current law, VA appeals framework is complex, ineffective, and opaque, and veterans wait on average 5 years for final resolution of an appeal. The 2017 Budget supports the development of a Simplified Appeals Process to provide

veterans with a simple, fair, and streamlined appeals procedure in which they would receive a final appeals decision within 365 days from filing of an appeal by FY 2021. The 2017 Budget provides funding to support over 900 FTE for the Board and proposes a legislative change that will improve an outdated and inefficient process which will benefit all veterans through expediency and accuracy. We look forward to working with Congress, Veterans, and other stakeholders to implement improvements.

- **Fiduciary program.** The fiduciary program served 29 percent more beneficiaries in 2015 than it served in 2014. Program growth is primarily due to an increase in the total number of individuals receiving VA benefits and an aging population of beneficiaries. Additionally, in 2015 the fiduciary program changed the way it captures beneficiary population data and now reports all beneficiaries served during the course of the fiscal year. In 2015, fiduciary personnel conducted more than 84,000 field examinations, and VBA anticipates field examination requirements will exceed 97,000 in 2017.
- **Housing program.** The 2017 Budget includes \$34 million for the VA Loan Electronic Reporting Interface (VALERI) to manage the 2.4 million VA-guaranteed loans for Veterans and their families. VALERI connects VA with more than 320,000 Veteran borrowers and more than 225,000 mortgage servicer contacts. VA uses the VALERI tool to manage and monitor efforts taken by private-sector loan servicers and VA staff in providing timely and appropriate loss mitigation assistance to defaulted borrowers. Without these resources, approximately 90,000 Veterans and their families would be in jeopardy of losing their homes each year, potentially costing the government an additional \$2.8 billion per year. VALERI also supports payment of guaranty and acquisition claims.

The Budget requests the following advance appropriations amounts for 2018: \$90.1 billion for compensation and pensions, \$13.7 billion for readjustment benefits, and \$107.9 million for insurance and indemnities. VA will continue to closely monitor workload and monthly expenditures in these programs and will revise cost estimates as necessary in the Mid-Session Review of the 2017 Budget, to ensure the enacted advance appropriation levels are sufficient to address anticipated Veteran needs throughout the year.

The Simplified Appeals Initiative

The current VA appeals process is broken. The more than 80-year-old process was conceived in a time when medical treatment was far less frequent than it is today, so it is encumbered by some antiquated laws that have evolved since WWI and steadily accumulated in layers.

Under current law, the VA appeals framework is complex, ineffective, confusing, and understandably frustrating for Veterans who wait much too long for final resolution of their appeal. The current appeals system has no defined endpoint, and multiple

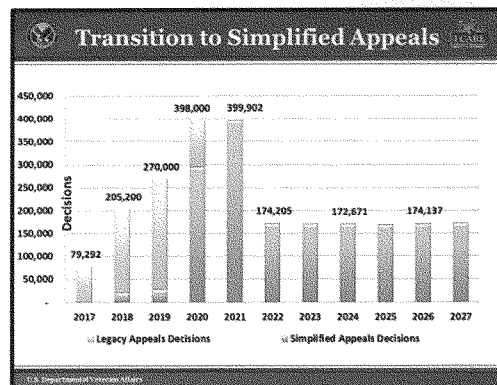
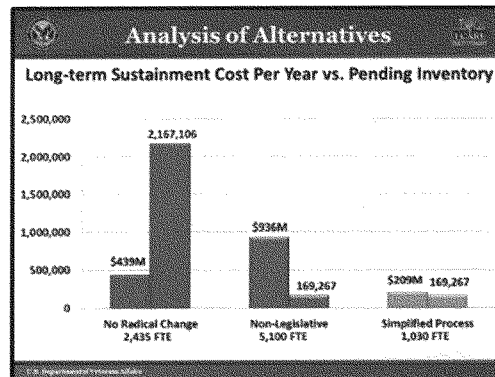
steps are set in statute. The system requires continuous evidence gathering and multiple re-adjudications of the very same or similar matter. A Veteran, survivor, or other appellant can submit new evidence or make new arguments at any time, while VA's duty to assist requires continuous development and re-adjudication. Simply put, the VA appeals process is unlike other standard appeals processes across Federal and judicial systems.

Fundamental legislative reform is essential to ensure that Veterans receive timely and quality appeals decisions, and we must begin an open, honest dialogue about what it will take for us to provide Veterans with the timely, fair, and streamlined appeals decisions they deserve. To put the needs, expectations, and interests of Veterans and beneficiaries first—a goal on which we can all agree—the appeals process must be modernized.

The 2017 Budget proposes a Simplified Appeals Process—legislation and resources (i.e., people, process, and technology) that would provide Veterans with a simple, fair, and streamlined appeals process in which they would receive a final decision on their appeal within one year from filing the appeal by FY 2021.

The 2017 Budget requests \$156.1 million and 922 FTE for the Board, an increase of \$46.2 million and 242 FTE above the FY 2016 enacted level. This is a down-payment on a long-term, sustainable plan to provide the best services to Veterans. This policy option also represents the best value to taxpayers (as outlined in the chart, Analysis of Alternatives).

Without legislative change or significant increases in staffing, VA will face a soaring appeals inventory, and Veterans will wait even longer for a decision on their appeal. If Congress fails to enact VA's proposed legislation to simplify the appeals process, Congress

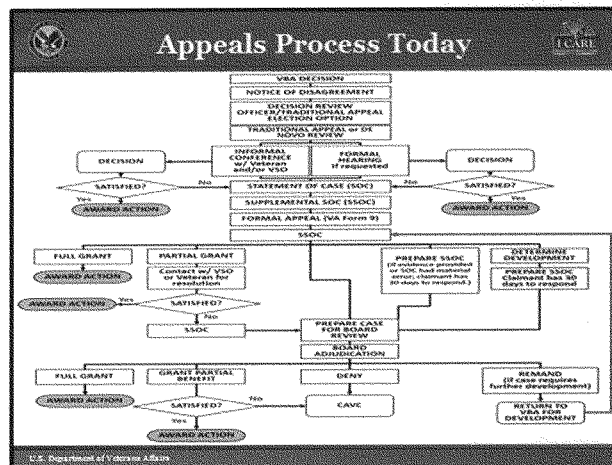


**Simplified Appeals Process:
Ramp Up and Long-Term Sustainment**

would need to provide resources for VA to sustain more than double its appeals FTE, with approximately 5,100 appeals FTE onboard. The prospect of such a dramatic increase, while ignoring the need for structural reform, is not a good result for Veterans or taxpayers.

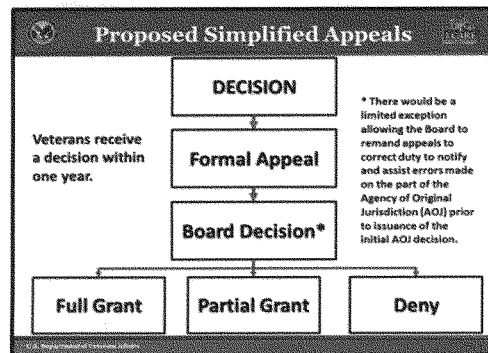
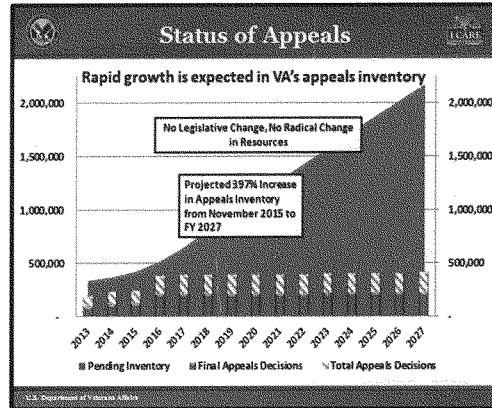
While the Simplified Appeals proposal would require FTE increases for the first several years to resolve the more than 440,000 currently pending appeals, by 2022, VA would be able to reduce appeals FTE to a sustainment level of roughly 1,030 FTE (including 980 FTE at the Board and 50 at VBA), a level sufficient to process all simplified appeals in one year. Notably, such a sustainment level is 1,135 FTE less than the current 2016 budget requires, and is 4,070 FTE less Department-wide than would be required to address this workload with FTE resources alone. In addition, this reform would essentially eliminate the need for appeals FTE at VBA, allowing these resources to be redirected within VBA to other priorities.

In 2015, the Board was still adjudicating an appeal that originated 25 years ago, even though the appeal had previously been decided by VA more than 27 times. Under the Simplified Appeals Process, most Veterans would receive a final appeals decision within one year of filing an appeal. Additionally, rather than trying to navigate a multi-step process that is too complex and too difficult to understand, Veterans would be afforded a transparent, single-step appeal process with only one entity responsible for processing the appeal. Essentially, under a simplified appeals process, as soon as a Veteran files an appeal, the case would go straight to the Board where a Judge would review the same record considered by the initial decision-maker and issue a final decision within one year; informing the Veteran whether that initial decision was substantially correct, contained an error that must be corrected, or was simply wrong. If a Veteran disagrees with any or all of the final appeals decision, the Veteran always has the option of filing a new claim for the same benefit once the appeal is resolved, or may pursue an appeal to the Court of Appeals for Veterans Claims.



In today's Convoluted Appeals Process, Veterans Wait 5 Years for a Decision

Rapid growth in the appeals workload exacerbates this challenge. As VBA has produced record-setting claims-decision output over the past five years, appeals volume has grown commensurately. Between December 2012 and November 2015, the number of pending appeals rose by 34 percent. Under current law with no radical change in resources, the number of pending appeals is projected to soar by 397 percent—from 437,000 to 2.17 million (chart, Status of Appeals)—between November 2015 and FY 2027.



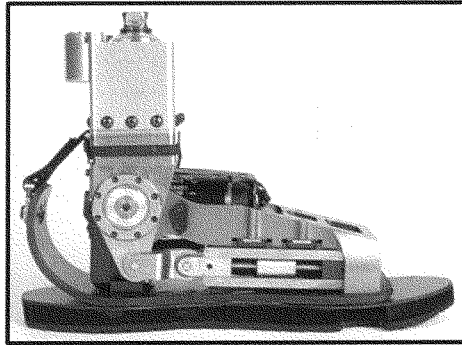
VA's Proposed Simplified Appeals Process:
Veterans Receive an Appeal Decision Within One Year

VA firmly believes that justice delayed is justice denied. In the streamlined appeals process proposed in the FY 2017 President's Budget (chart, Proposed Simplified Appeals), there would be a limited exception allowing the Board to remand appeals to correct duty to notify and assist errors made on the part of the Agency of Original Jurisdiction (AOJ) prior to issuance of the initial AOJ decision.

Medical and Prosthetic Research

The 2017 Budget continues VA's program of groundbreaking, high standard research focused on advancing the health care needs of all Veterans. The 2017 Budget requests \$663 million for Medical Research and supports the President's Precision Medicine Initiative (PMI) to drive personalized medical treatment and the evolving science of Genomic Medicine—how genes affect health. In addition to the direct appropriation, Medical Research will be supported through \$1.3 billion from VA's

Medical Care program and other Federal and non-Federal research grants. Total funding for Medical and Prosthetic Research will be more than \$2.0 billion in 2017.



The First Powered Ankle-Foot Prosthesis

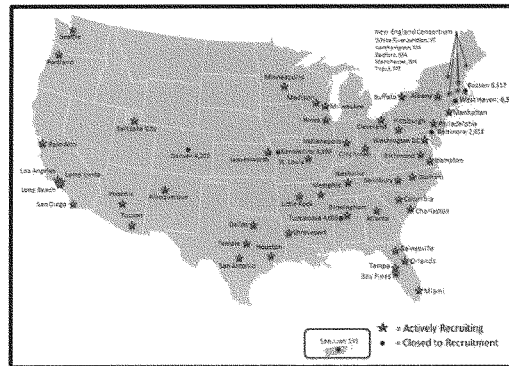
VA research is focused on the U.S. Veteran population and allows VA to uniquely address scientific questions to improve Veteran health care. Most VA researchers are also clinicians and health care providers who treat patients. Thus, VA research arises from the desire to heal rather than pure scientific curiosity and yields remarkable returns.

For more than 90 years, VA research has produced cutting-edge medical and prosthetic breakthroughs that improve the

lives of Veterans and others. The list

of accomplishments includes therapies for tuberculosis following World War II, the implantable cardiac pacemaker, computerized axial tomography (CAT) scans, functional electrical stimulation systems that allow patients to move paralyzed limbs, the nicotine patch, the first successful liver transplants, the first powered ankle-foot prosthesis, and a vaccine for shingles. VA researchers also found that one aspirin a day reduces by half the rate of death and nonfatal heart attacks in patients with unstable angina. More recently, VA investigators tested an insulin nasal spray that shows great promise in warding off Alzheimer's disease and found that prazosin (a well-tested generic drug used to treat high blood pressure and prostate problems) can help improve sleep and lessen nightmares for those with post-traumatic stress disorder.

Beyond VA's support of more than 2,200 continuing research projects, VA will leverage our Million Veteran Program (MVP)—already one of the world's largest databases of genetic information—to support several Precision Medicine Initiatives. The first initiative will evaluate whether using a patient's genetic makeup to inform medication selection is effective in reducing complications and getting patients the most effective medication for them. This



VA's Million Veteran Program Recruitment

initiative will focus on up to 21,500 Veterans with PTSD, depression, pain, and/or substance abuse.

The second initiative will focus on additional analysis of DNA specimens already collected in the MVP. More than 438,000 Veteran volunteers have contributed DNA samples so far. Genomic analysis on these DNA specimens allows researchers to extract critical genetic information from these specimens. There are several possible "levels" of genomic analyses, with increasing cost.

Built into the design of MVP and currently funded within the VA research program is a process known as "exome chip" genotyping—the tip of the iceberg in genomic analysis. Exome Chip genotyping provides useful information, but newer technologies promise significantly greater information for improving treatments. VA proposes conducting the next level of analysis, known as "exome sequencing," on up to 100,000 Veterans who are enrolled in MVP. This exome sequencing analyzes the part of the genome that codes for proteins—the large, complex molecules that perform most critical functions in the body. Sequencing efforts will begin with a focus on Veterans with PTSD and frequently co-occurring conditions such as depression, pain, and substance abuse, and expand to other chronic illnesses such as diabetes and heart disease, among others. This more detailed genetic analysis will provide greater information on the biological factors that may cause or increase the risk for these illnesses.

VA's research and development program improves the lives of Veterans and all Americans through health care discovery and innovation.

Other Priorities

Information Technology

The 2017 Budget demonstrates VA's commitment to using cutting-edge information technology (IT) to support transformation and ensure that the Veteran is at the center of everything we do. The Budget requests \$4.28 billion—an increase of \$145 million (3.5 percent) from the 2016 enacted level—to help stabilize and streamline core processes and platforms, eliminate the information security material weakness, and institutionalize new capabilities to deliver improved outcomes for Veterans. The request includes \$471 million for new efforts to develop, improve, and enhance clinical and benefits systems and processes and supports VA's strategy to replace FMS. The 2017 Budget was developed through Federal IT Acquisition Reform Act (FITARA) compliant processes led by the Chief Information Officer (CIO), in concert with the Chief Financial Officer and Chief Acquisition Officer.

In FY 2015, the Office of Information and Technology (OIT) developed an IT Enterprise Strategy and an Enterprise Cybersecurity Strategy. These strategies support OIT's vision to become a world-class organization that provides a seamless, unified Veteran experience through the delivery of state-of-the-art technology. OIT is implementing a new IT Security Strategy to improve VA's security posture and eliminate the Federal Information Security Management Act/Federal Information System Controls Audit Manual material weakness.

The 2017 Budget includes \$370.1 million for information security, an increase of 105 percent over the FY 2016 funding level. In addition, the 2017 Budget includes \$50 million to launch a new Data Management program to use data as a strategic resource. Under this program, VA will inventory its data collection activities—with the objective of requesting data from the Veteran only once—and dispose expired information in a secure and timely way. These two aspects will reduce VA costs for data storage and support safeguards for Veterans' information.

National Cemetery Administration

The National Cemetery Administration (NCA) has the solemn duty to honor Veterans and their families with final resting places in national shrines and with lasting tributes that commemorate their service and sacrifice to our Nation. The 2017 Budget requests \$286 million, an increase of \$15 million (5.5 percent) to allow VA to provide perpetual care for more than 3.5 million gravesites and more than 8,800 developed acres. The Budget supports NCA's efforts to raise and realign gravesites and repair turf in order to maintain cemeteries as national shrines. The Budget also continues implementation of a Geographic Information System to enable enhanced accounting of remains and gravesites and enhanced gravesite location for visitors. The Budget positions NCA to meet Veterans' emerging burial and memorial needs in the decades to come by ensuring that Veterans and their families continue to have convenient access to a burial option in a National, state, or tribal Veterans cemetery and that the service they receive is dignified, respectful, and courteous.

VA Infrastructure

The 2017 Budget requests \$900.2 million for VA's Major and Minor construction programs. The Budget invests in infrastructure projects at existing campuses that will lead to seismically safe facilities, ensuring that Veterans are safe when they seek care. The capital asset budget request demonstrates VA's commitment to address critical Major construction projects that directly affect patient safety and seismic issues, and reflects VA's promise to provide safe and secure facilities for Veterans. The 2017 Budget also requests funding to ensure that VA has the ability to provide eligible Veterans with access to burial services through new and expanded cemeteries, and prevent the closure to new interments in existing cemeteries.

VA acknowledges the transformation underway in the landscape for health care delivery. Our future space needs may be impacted by the changes we are already implementing in how we deliver care for Veterans. In addition, we plan to potentially incorporate any recommendations from the Commission on Care and their impact on our changing service delivery into our long-term infrastructure strategy.

Leasing provides flexibility and enables VA to more quickly adapt to changes in medical technology, workload, new programs, and demographics. VA is also looking to Congress for authorization of 18 leases submitted in VA's FY 2015 and 2016 Budget requests. The pending major medical facility lease projects will replace, expand, or create new outpatient clinics and research facilities and are critical for providing access for Veterans and enhancing our research capabilities nationwide. The 2017 Budget

includes a request to authorize six additional replacement major medical facility leases under VA's authority in 38 U.S.C. §§ 8103 and 8104 and with the anticipated delegation of leasing authority from the General Services Administration. The Department is awaiting authorization of its request to expand the definition of "Medical Facilities" in VA's authorizing statutes to allow VA to more easily partner with other Federal agencies. Another proposal that deserves attention is authorization of enhanced use lease (EUL) authority to encompass broader possibilities for mixed-use projects. This change would give VA more opportunities to engage the private sector, local governments, and community partners by allowing VA to use underutilized property that would benefit Veterans and VA's mission and operations.

Major Construction

The 2017 Budget requests \$528.1 million for Major Construction. The request includes funds to address seismic problems in facilities in Long Beach, California, and Reno, Nevada. These projects will correct critical safety and seismic deficiencies that pose a risk to Veterans, VA staff, and the public. Consistent with Public Law 114-58, the Department must identify a non-VA entity to execute these two projects, as they are more than \$100 million. We have identified the U.S. Army Corps of Engineers as our construction agent to execute these projects.



San Fernando Medical Center collapse, 1971

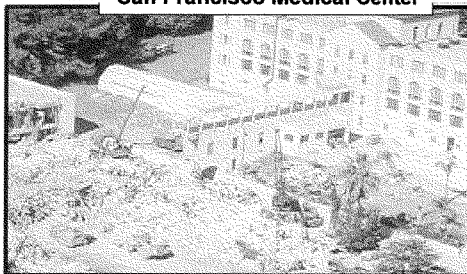
We must prevent the devastation and potential loss of life that may occur because our facilities are vulnerable to earthquakes—such as the one that occurred in 1971 in San Fernando, California. As shown, a 6.5-magnitude earthquake caused two buildings in the San Fernando Medical Center to collapse and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

These images show a known seismic deficiency at the San Francisco Medical Center—built in 1933—wherein the rebar does not extend into the “pile cap.”

The request also includes funding for new national cemeteries in western New York and southern Colorado, and national cemetery expansions in Jacksonville, Florida and South Florida. These cemetery projects support NCA's goal to ensure that eligible Veterans have access to a burial option within a reasonable distance from their residences.



San Francisco Medical Center



- The new western New York national cemetery will establish a dignified burial option for more than 96,000 Veterans plus eligible family members in the western New York region.
- The new southern Colorado national cemetery will establish a dignified burial option for more than 95,000 Veterans plus eligible family members in the southern Colorado region.
- The Jacksonville National Cemetery expansion will develop approximately 30 acres of undeveloped land to provide approximately 20,200 gravesites.
- The South Florida National Cemetery expansion will develop approximately 25 acres of undeveloped land to provide approximately 21,750 gravesites.

Minor Construction

In 2017, the Budget requests \$372 million for Minor Construction. The requested amount would provide funding for ongoing projects that renovate, expand and improve VA facilities, while increasing access for our Veterans. Examples of projects include enhancing women's health programs; providing additional domiciliaries to further address Veterans' homelessness; improving safety; mitigating seismic deficiencies; transforming facilities to be more Veteran-centric; enhancing patient privacy; and enhancing research capabilities.

The Minor Construction request will also provide funding for gravesite expansion and columbaria projects to keep existing national cemeteries open, and will support NCA's urban and rural initiatives. It will also provide funding for projects at VBA regional offices nationwide and will fund infrastructure repairs and enhancements to improve operations for the Department's staff offices.

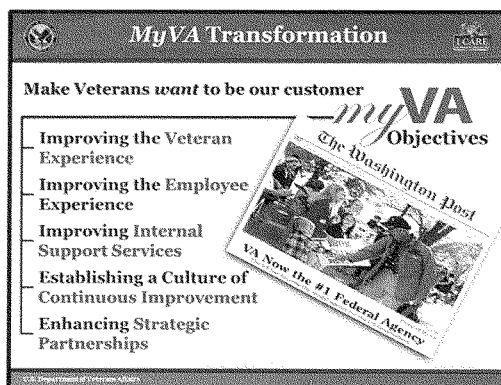
Leasing

The 2017 Budget includes a request to authorize six replacement major medical facility leases located in Corpus Christi, Texas; Jacksonville, Florida; Pontiac, Michigan; Rochester, New York; Tampa, Florida; and Terre Haute, Indiana. These leases will allow VA to provide continued access to Veterans that are served in these locations.

MyVA Transformation

MyVA puts Veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider—a framework for modernizing VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. A Veteran walking into any VA facility should have a consistent, high-quality experience.

MyVA will build upon existing strengths to promote an environment where VA employees see themselves as members of one enterprise, fortified by our diverse backgrounds, skills, and abilities. Moreover, every VA employee—doctor, rater, claims processor, custodian, or support staffer, or the Secretary of Veterans Affairs—will understand how they fit into the bigger picture of providing Veteran benefits and services. VA, of course, must also be a good steward of public resources. Citizens and taxpayers should expect to see efficiency in how we run our internal operations.



The FY 2017 budget will make investments toward the five critical MyVA objectives:

1. **Improving the Veteran experience:** At a bare minimum, every contact between Veterans and VA should be predictable, consistent, and easy; however, we are aiming to make each touchpoint exceptional. It begins with receptionists who are pleasant to our Veteran clients, but there is also a science to this experience. We are focusing on human-centered design, process mapping, and working with leading design firms to learn and use the technology associated with improving every interaction with clients.
2. **Improving the employee experience—so we can better serve Veterans:** VA employees are the face of VA. They provide care, information, and access to earned benefits. They serve with distinction daily. We cannot make things better

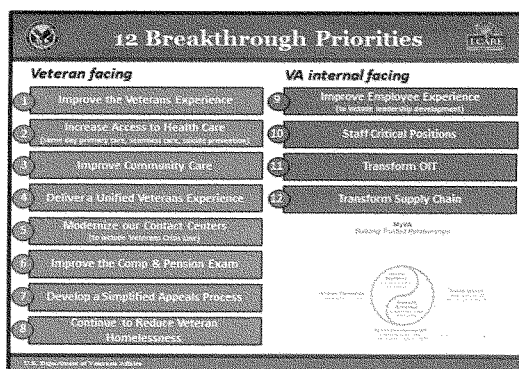
for Veterans without improving the work experience of our dedicated employees. We must train them. We must move from a rules/fear-based culture to a principles/values-based culture. I learned in the private sector that it is absolutely not a coincidence that the very best customer-service organizations are almost always among the best places to work.

3. **Improving internal support services:** We will let employees and leaders focus on assisting Veterans, rather than worrying about "back office" issues. We must bring our IT infrastructure into the 21st century. Our scheduling system, where many of our issues with access to care were manifest, dates to 1985. Our Financial Management System is written in COBOL, a language I used in 1973. This is simply unacceptable. It impedes all of our efforts to best serve Veterans.
4. **Establishing a culture of continuous improvement:** We will apply Lean strategies and other performance improvement capabilities to help employees examine their processes in new ways and build a culture of continuous improvement.
5. **Enhancing strategic partnerships:** Expanding our partnerships will allow us to extend the reach of services available for Veterans and their families. We must work effectively with those who bring capabilities and resources to help Veterans.

Breakthrough Priorities for CY 2016

While we have made progress, we are still on the first leg of a multi-year journey. We have narrowed down our near-term focus to 12 "breakthrough priorities."

Many of these reflect issues which are not new—they have been known problems, in some cases, for years. We have already seen some progress in solving many of them. However, we still have much work to do.



The following are our 12 priorities and the 2016 outcomes to which we aspire. We understand that it will be a challenge to accomplish all of these goals this year, but we have committed ourselves to producing results for Veterans and creating irreversible momentum to continue the transformation in future years.

Veteran Facing Goals

1. Improve the Veteran Experience.

- **Breakthrough Outcome for 2016:**
 - Strengthen the trust in VA to fulfill our country's commitment to Veterans; currently measured at 47 percent, we want it to be 70 percent by year end.
 - Establish a Department-wide customer experience measurement framework to enable data-driven service improvements.
 - Make the Veterans Experience office fully operational.
 - Expand the network of Community Veteran Engagement Boards to more than 100.
 - Additionally, in order to deliver experiences to Veterans that are effective, easy, and in which Veterans feel valued, medical centers will ensure that they are fully staffed at the frontline with well-prepared employees who have been selected for their customer service. Functionally, this means new frontline staff will be assessed through a common set of customer service criteria, hired within 30 days of selection, and provided a nationally standardized onboarding and training program.

2. Increase Access to Health Care.

- **Breakthrough Outcome for 2016:**
 - When Veterans call or visit primary care facilities at a VA Medical Center, their clinical needs will be addressed the same day.
 - When Veterans call for a new mental health appointment, they receive a suicide risk assessment and immediate care if needed. Veterans already engaged in mental health care identifying a need for urgent attention will speak with a provider the same day.
 - Utilizing existing VistA technology, Veterans will be able to conveniently get medically necessary care, referrals, and information from any VA Medical Center, in addition to the facility where they typically receive their care.

3. Improve Community Care.

- **Breakthrough Outcome for 2016:** Improve the Veterans' experience with Care in the Community. Following enactment of our requested legislation, by the end of the year:
 - VA will begin to consolidate and streamline its non-Department Provider Network and improve relationships with community providers and core partners.
 - Veterans will be able to see a community provider within 30 days of their referral.
 - Non-Department claims will be processed and paid within 30 days, 85 percent of the time.

- Health care claims backlog will be reduced to less than 10 percent of total inventory.
- Referral and authorization time will be reduced.

4. Deliver a Unified Veteran Experience.

- Breakthrough Outcome for 2016:
 - Vets.gov will be able to provide Veterans, their families, and caregivers with a single, easy-to use, and high-performing digital platform to access the VA benefits and services they have earned.
 - Vets.gov will be data-driven and designed such that the top 100 search terms will be available within one click from search results. The top 100 search terms will all be addressed within one click on the site.
 - All current content, features and forms from the current public-facing VA websites will be redesigned, rewritten in plain language, and migrated to Vets.gov, in priority order based on Veteran demand.
 - Additionally, we will have one authoritative source of customer data; eliminating the disparate streams of Administration-specific data that require Veterans to replicate inputs.

5. Modernize our Contact Centers (Including Veterans Crisis Line).

- Breakthrough Outcome for 2016:
 - Veterans will have a single toll free phone number to access the VA Contact Centers, know where to call to get their questions answered, receive prompt service and accurate answers, and be treated with kindness and respect. VA will do this by establishing the initial conditions necessary for an integrated system of customer contact centers.
 - By the end of this year, every Veteran in crisis will have his or her call promptly answered by an experienced responder at the Veterans Crisis Line.

6. Improve the Compensation & Pension (C&P) Exam Process.

- Breakthrough Outcome for 2016:
 - Improved Veteran satisfaction with the C&P Exam process. We have a baseline satisfaction metric in place and have established a goal for significant improvement.
 - VA will have a national rollout of initiatives to ensure the experience is standardized across the Nation.

7. Develop a Simplified Appeal Process.

- Breakthrough Outcome for 2016:
 - Subject to successful legislative action, put in place a simplified appeals process, enabling the Department to resolve 90 percent of appeals within one year of filing by 2021.

- Increase current appeals production to more rapidly reduce the existing appeals inventory.

8. Continue Progress in Reducing Veteran Homelessness.

- Breakthrough Outcome for 2016:
 - Continue progress toward an effective end to Veteran homelessness by permanently housing or preventing homelessness for an additional 100,000 Veterans and their family members,

VA Internal Facing Goals

9. Improve the Employee Experience (Including Leadership Development).

- Breakthrough Outcome for 2016:
 - Continue to improve the employee experience by developing engaged leaders at all levels who inspire and empower all employees to deliver a seamless, integrated, and responsive VA customer service experience.
 - More than 12,000 engaged leaders skilled in applying LDL principles, concepts, and tools will work projects and/or initiatives to make VA a more effective and efficient organization.
 - Improve VA's employee experience by incorporating LDL principles into VA's leadership and supervisor development programs and courses of instruction.
 - VA Senior Executive performance plans will include an element that targets how to improve employee engagement and customer service, and all VA employees will have a customer service standard in their performance plans.
 - All VA supervisors will have a customer service standard in their performance plans.
 - VA will begin moving from paper-based individual development plans to a new electronic version, making it easier for both supervisors and employees.

10. Staff Critical Positions.

- Breakthrough Outcome for 2016:
 - Achieve significantly improved critical staffing levels that balance access and clinical productivity, with targets of 95 percent of Medical Center Director positions filled with permanent appointments (not acting) and 90 percent of other critical shortages addressed—management as well as clinical.
 - Work to reduce "time to fill" hiring standards by 30 percent.

11. Transformation the Office of Information & Technology (OIT).

- Breakthrough Outcome for 2016: Achieve the following key milestones on the path to creating a world-class IT organization that improves the support to business partners and Veterans.

- Begin measuring IT projects based on end product delivery, starting with a near-term goal to complete 50 percent of projects on time and on budget.
- Stand up an account management office.
- Develop portfolios for all Administrations.
- Tie all supervisors' and executives' performance goals to strategic goals.
- Close all current cybersecurity weaknesses.
- Develop a holistic Veteran data management strategy.
- Implement a quality and compliance office.
- Deploy a transformational vendor management strategy.
- Ensure implementation of key initiatives to improve access to care.
- Establish one authoritative source for Veteran contact information, military service history, and Veteran status.
- Finalize the Congressionally mandated DoD-VA Interoperability requirements.

12. Transform Supply Chain.

- *Breakthrough Outcome for 2016:*
 - Build an enterprise-wide integrated Medical-Surgical supply chain that leverages VA's scale to drive an increase in responsiveness and a reduction in operating costs. More than \$150 million in cost avoidance will be redirected to priority Veteran programs.

We are rigorously managing each of these "breakthrough priorities" by instituting a Department level scorecard, metrics, and tracking system. Each priority has an accountable and responsible official and a cross-functional, cross-Department team in support. Each team meets every other week in person with either the Secretary or Deputy Secretary to discuss progress, identify roadblocks, and problem solve solutions. This is a new VA—more transparent, collaborative, and respectful; less formal and bureaucratic; more execution and outcome-focused; principles based, not rules-based.

Legislative Priorities

The Department is grateful for your continuing support of Veterans and appreciates your efforts to pass legislation enabling VA to provide Veterans with the high-quality care they have earned and deserve. We have identified a number of necessary legislative items that require action by Congress in order to best serve Veterans going forward:

1. **Improve Care in the Community:** We need your help, as discussed on many occasions, to help overhaul our Care in the Community programs. VA staff and subject matter experts have communicated regularly with congressional staff to discuss concepts and concerns as we shape the future plan and recommendations. We believe that together we can accomplish legislative

changes to streamline Care in the Community programs before the end of this session of Congress.

2. **Flexible Budget Authority:** We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are more than 70 line items in VA's budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs. These restrictions limit VA's ability to deliver Veteran care and benefits based on demand, rather than specific funding lines. The 2017 Budget proposes appropriations language to provide VA with new authority to transfer up to two percent of the discretionary appropriations for fiscal year 2017 between any of VA's discretionary appropriations accounts, excluding Medical Care. This new authority would give VA greater ability to address emerging needs and overcome artificial funding restrictions on providing Veterans' care and benefits.

3. **Support for the Purchased Health Care Streamlining and Modernization Act:** This legislation would clarify VA's ability to contract with providers in the community on an individual basis, outside of Federal Acquisition Regulations (FAR), without forcing providers to meet excessive compliance burdens, while maintaining essential worker protections. The proposal allows this option only when care directly from VA or from a non-VA provider with a FAR-based agreement in place is not feasibly available. Already, we have seen certain nursing homes not renew their agreements with VA because of the excessive compliance burdens, and as a result, Veterans are forced to find new nursing home facilities for residence.

 VA further requests your support for our efforts to recruit and retain the very best clinical professionals. These include, for example, flexibility for the Federal work period requirement, which is inconsistent with private sector medicine, and special pay authority to help VA recruit and retain the best talent possible to lead our hospitals and health care networks.

4. **Special Legislation for VA's West Los Angeles Campus:** VA has requested legislation to provide enhanced use leasing authority that is necessary to implement the Master Plan for our West Los Angeles Campus. That plan represents a significant and positive step for Veterans in the Greater West Los Angeles area, especially those who are most in need. We appreciate the Committee's hearing in December 2015 on legislation to implement that Master Plan, and VA urges your support for expedited consideration of this bill to secure enactment of it in this session of Congress. Enactment of the legislation will allow us to move forward and get positive results for the area's Veterans after years of debate in the community and court action. This bill would reflect the settlement of that litigation, and truly be a win-win for Veterans and the community. I believe this is a game-changing piece of legislation as it highlights the opportunities that are possible when VA works in partnership with the community.

5. **Overhaul the Claims Appeals Process:** As mentioned earlier, VA needs legislation that sets out structural reforms that will allow VBA and the Board to provide Veterans with the timely, fair, and quality appeals decisions they deserve thereby addressing the growing inventory of appeals.

Lastly, let me again remind everyone that the vast majority of VA employees are hard workers who do the right thing for Veterans every day. However, we need your assistance in supporting the cultural change we are trying to drive. We are working to change the culture of VA from one of rules, fear, and reprisals to one of principles, hope, and gratitude. We need all stakeholders in this transformation to embrace this cultural transformation, including Congress. In fact, I think Congress, above all, recognizes the policy window we have at hand and must have the courage to make the type of changes it is asking VA and our employees to make. Congress can only put Veterans first by caring for those who serve Veterans.

Our dedicated VA employees, if given the right tools, training, and support, can and go out of their way to provide the best care possible to our Veterans and their families.

Closing

VA exists to serve Veterans. We have spent the last year and a half working to find new and better ways to provide high quality care and administer benefits effectively and efficiently through responsible use of taxpayer dollars. We will continue to face enormous challenges, and this budget request will provide the resources needed to continue the transformation of this Department.

This budget and associated legislative proposals will allow us to streamline care for Veterans and improve access by addressing existing gaps, develop a simplified appeals process, further the progress we have made to eliminate the VBA claims backlog and end Veteran homelessness, and improve our cyber security posture to protect Veteran and employee data. It will also allow us to continue implementing MyVA to guide overall improvements to VA's culture, processes, and capabilities.

I have pledged that VA will ensure that the funds Congress appropriates to VA will be used to improve both the quality of life for Veterans and the efficiency of our operations. I am proud to continue this work and recognize there is much left to be done. We have made great strides and are grateful for the support of Congress through this transformation.

Thank you for the opportunity to appear before you today and for your continued steadfast support of Veterans. We look forward to your questions.



Department of Veterans Affairs
Senior Executive Biography

Robert A. McDonald
Secretary of Veterans Affairs



Robert A. McDonald was nominated by President Obama to serve as the eighth Secretary of Veterans Affairs and was confirmed by the United States Senate on July 29, 2014.

Prior to joining VA, Secretary McDonald was Chairman, President, and Chief Executive Officer of The Procter & Gamble Company (P&G). Under his leadership, P&G significantly recalibrated its product portfolio; expanded its marketing footprint, adding nearly one billion people to its global customer base; and grew the firm's organic sales by an average of three percent per year. This growth was reflected in P&G's stock price, which rose from \$51.10 the day he became CEO to \$81.64 on the day his last quarterly results were announced—a 60 percent increase from 2009 to 2013.

During his tenure, P&G was widely recognized for its leader development prowess. In 2012, Chief Executive Magazine named it the best company for developing leader talent. The Hay Group, a global management consulting firm, consistently cited P&G in its top-tier listing of the Best Companies for Leadership Study. The company received recognition for its environmental and social sustainability initiatives, including receipt of the Department of State's Award for Corporate Excellence for P&G's operations in Pakistan and Nigeria. In addition, using the company's innovative water purification packets, P&G committed itself to the 2020 goal of "saving one life every hour" by annually providing two billion liters of clean drinking water to people in the world's developing countries.

An Army veteran, Mr. McDonald served with the 82nd Airborne Division; completed Jungle, Arctic, and Desert Warfare training; and earned the Ranger tab, the Expert Infantryman Badge, and Senior Parachutist wings. Upon leaving military service, Captain McDonald was awarded the Meritorious Service Medal.

Secretary McDonald graduated from the United States Military Academy at West Point in the top 2 percent of the Class of 1975. He served as the Brigade Adjutant for the Corps of Cadets and was recognized by The Royal Society for the Encouragement of Arts, Manufacturing, and Commerce as the most distinguished graduate in academics, leadership, and physical education. He earned an MBA from the University of Utah in 1978.

The Secretary is personally committed to values-based leadership and to improving the lives of others. He and his wife, Diane, are the founders of the McDonald Cadet Leadership Conference at West Point—a biennial gathering that brings together the best and brightest young minds from the best universities around the world and pairs them with senior business, NGO, and government leaders in a multi-day, interactive learning experience.

The recipient of numerous leadership awards and honorary degrees, in 2014, Secretary McDonald was awarded the Public Service Star by the President of the Republic of Singapore for his work in helping to shape Singapore's development as an international hub for connecting global companies with Asian firms and enterprises.

Secretary McDonald and his wife are the parents of two grown children, and the proud grandparents of two grandsons.



Department of Veterans Affairs
Senior Executive Biography

LaVerne H. Council, MBA, DBA
Assistant Secretary for Information and Technology
and Chief Information Officer,
Office of Information and Technology



Ms. LaVerne H. Council joined the Department of Veterans Affairs in July 2015 as the Assistant Secretary for Information and Technology (OI&T) and Chief Information Officer. In this role, Ms. Council oversees the day-to-day activities of VA's \$4 billion IT budget and over 8,000 IT employees to ensure that VA has the IT tools and services needed to support our Nation's Veterans.

Prior to joining VA, Ms. Council served as CEO of Council Advisory Services, LLC and Chair of the National Board of Trustees for the March of Dimes. In December 2011, she retired from Johnson & Johnson after serving as Corporate Vice President and Chief Information Officer for Johnson & Johnson's global Information Technology group. In this capacity, she was responsible for managing information technology and related systems for the \$61.6B Johnson & Johnson worldwide enterprise. She was a Member of the Corporate Global Operating Committee and her organization included more than 250 operating companies with over 4,000 information technology employees and 7,000 contractors.

Ms. Council is a proven visionary senior executive with global experience in the development and execution of cutting-edge information technology and supply chain strategies in the healthcare/life sciences, consumer products and telecommunications/hi-tech industries. In 2011, Ms. Council received the Alumni Business Achievement Award from Ernst & Young. Business Trends Quarterly named her as one of the top four CIOs in America in 2010. The New Jersey Technology Council inducted her into their CIO Hall of Fame in 2009, and the Global CIO Executive Summit named her a Top 10 Leader and Change Agent in 2009 and a Top 10 Leader and Innovator in 2008. CAREER CHRONOLOGY:

2015 – Present	Assistant Secretary, Information and Technology, Department of Veterans Affairs
2012 – 2015	CEO, Council Advisory Services, LLC
2011 – Present	Chairperson of the National Board of Trustees, March of Dimes Foundation
2006 – 2011	Corporate Vice President and Chief Information Officer, Johnson & Johnson
2000 – 2006	Global Vice President for Information Technology, Global Business Solutions and Development Services, Dell, Inc.

Ms. Council was also a partner with Ernst and Young and led the company's Global Supply Chain Strategy practice. She also held leadership positions focusing on infrastructure engineering, networking, security and enterprise application interfaces.

EDUCATION:

2010	Doctorate of Business Administration, Drexel University, Philadelphia, PA
1986	Master of Business Administration, Operations Management from Illinois State University, St. Normal, IL
1983	Bachelor of Science in Business, Western Illinois University, Macomb,



Department of Veterans Affairs

Senior Executive Biography

Edward Joseph Murray

Interim Assistant Secretary for Management and Interim Chief Financial Office

Edward Joseph Murray was appointed as the Interim Assistant Secretary for Management and Interim Chief Financial Officer for the Department of Veterans Affairs on April 1, 2015. In this role, he is responsible for the overall budget and financial management of VA's \$163+ billion budget as well as the Department's performance management, business oversight, asset enterprise management, and corporate analysis and evaluations programs. Prior to assuming these duties, Mr. Murray served as the Principal Deputy Assistant Secretary (PDAS) for the Office of Management. As the PDAS, Mr. Murray was the principle advisor to the Assistant Secretary for Management on operations including budget, performance management, business oversight, enterprise risk management, and asset enterprise management programs. Mr. Murray also served as VA's Deputy Chief Financial Officer (DCFO).



Mr. Murray served as the Executive Director for Operations, Office of Management from February 2014 to July 2014. Between December 2004 and February 2014, Mr. Murray served as VA's Deputy Assistant Secretary for Finance and DCFO, responsible for Department-wide financial policy formulation and financial statement preparation; managing enterprise financial operations, including VA's Financial Services Center in Austin, Texas, and VA's Debt Management Center in St. Paul, Minnesota; and corporate financial applications including VA core accounting, payroll, and human resources management systems.

Mr. Murray also served as the Associate Deputy Assistant Secretary for Financial Systems where he was responsible for VA enterprise-wide accounting, payment, and human resource management systems from 2001-2004. Prior to joining VA in June 2001, Mr. Murray served as the Chief Technology Officer to the Coast Guard's CFO and Senior Procurement Executive and was responsible for Coast Guard's financial, budgetary, and acquisition systems. Prior to joining the Federal government in the early 1990's, Mr. Murray enjoyed an extensive private-sector career developing and managing a diverse range of information technology and business system projects spanning over 15 years.

Mr. Murray has received numerous civil service awards to include twice being a Presidential Rank Award (Meritorious) recipient, in 2006 and 2011. Further recognition includes the 2011 Association of Government Accountants Achievement of the Year Award and completion of VA's Executive Fellows Program in 2007. Mr. Murray has also received numerous distinguished awards from the Commandant of the Coast Guard, Secretary of Transportation and the American Society of Military Comptrollers for his innovative leadership in implementing commercial technology in Federal government. Mr. Murray received his Bachelor of Science degree in Accounting from Virginia Tech in Blacksburg, Virginia, and a Masters degree in Information Systems Management from the University of Denver.

Updated November 2015



Department of Veterans Affairs
Senior Executive Biography

Danny Pummill, MNSS, MMAS

**Acting Under Secretary for Benefits
Veterans Benefits Administration**

Danny Pummill was appointed Acting Under Secretary for Benefits in the Department of Veterans Affairs on October 19, 2015. In this position, he leads more than 20,000 employees in the Veterans Benefits Administration (VBA) in the delivery of non-medical benefits programs for Veterans, including disability compensation, pension and fiduciary, education, home loan guaranty, life insurance, vocational rehabilitation and employment, and transition, employment and economic impact. Through a nationwide network of 56 regional offices, special processing centers, and VBA Headquarters, he directs the execution of nearly \$90B in direct benefits to Veterans and their dependents.



Mr. Pummill was appointed to the Senior Executive Service in September 2007. Before becoming Acting Under Secretary, he served as Principal Deputy Under Secretary for Benefits, second in command in VBA. Prior to that role, he served as Director of VBA Department of Defense Program Office, Deputy Director for Policy and Procedures in the office of Compensation and Pension Services, Veterans Benefits Administration in Washington D.C., and as a Senior Executive for the Department of the Army. While with the Army he served as the primary advisor to the Assistant Secretary of the Army (Manpower and Reserve Affairs) responsible for policy and performance oversight for human resources (civilian and military), equal opportunity, equal employment opportunity, training, readiness, mobilization, military health affairs, force structure, manpower management, recruiting, and other critical matters as part of the Army leadership team.

CAREER CHRONOLOGY:

2015 – Present	Acting Under Secretary for Benefits, Veterans Benefits Administration
2013 – 2015	Principal Deputy Under Secretary for Benefits, Veterans Benefits Administration
2012 – 2013	Director, Veterans Benefits Administration, Department of Defense Program Office Veterans Benefits Administration
2010 - 2012	Deputy Director for Policy and Procedures, Office of Compensation and Pension Services, Department of Veterans Affairs, Veterans Benefits Administration
2007 - 2009	Deputy Assistant Secretary of the Army for Medical and Health Operations, Office of Assistant Secretary of the Army Manpower and Reserve Affairs, Headquarters, Department of the Army
2003 - 2007	Director of Operations, Assistant Secretary of the Army Manpower and Reserve Affairs, Headquarters, Department of the Army
2002 - 2003	Student, National War College, Fort McNair, Washington DC

.2001 - 2002 Executive Officer to the Deputy Assistant Secretary of the Army for Human Resources, Headquarters, Department of the Army

MAJOR MILITARY ASSIGNMENTS/AWARDS/DECORATIONS:

Mr. Pummill retired as a Colonel from the United States Army after serving for 33 years. He served as an Adjutant General Corps Officer and an enlisted Field Artillery and Infantry soldier in a variety of assignments. He has served at every level in the Army from squad through Headquarters Department of the Army. Commanding two separate Battalions, his duties have taken him to Panama, Central America, Korea, Europe, the Balkans, the Middle East and various locations throughout the United States.

EDUCATION:

2007 Wharton School of Business Advanced Management Program
 2002 Masters in National Security Strategy (MNSS), National War College, Fort McNair, Washington DC
 1996 Masters in Military Arts and Sciences (MMAS), Army Command and General Staff College, Leavenworth, KS
 1983 BS in Law Enforcement, Northern Michigan University, Marquette, MI

AWARDS AND HONORS:

Legion of Merit U.S. Army
 Horatio gates Gold Medal
 National School Board Award
 Horatio Gates Silver Medal



Department of Veterans Affairs
Senior Executive Biography

David J. Shulkin, M.D.
Under Secretary for Health
Veterans Health Administration (VHA)

The Honorable Dr. David J. Shulkin is Under Secretary of Health for the United States Department of Veterans Affairs. As the Chief Executive of the Veterans Health Administration, Dr. Shulkin leads the nation's largest integrated health care system with over 1,700 sites of care, serving 8.76 million Veterans each year. The Veterans Health Administration is also the nation's largest provider of graduate medical education and major contributor of medical research. Dr. Shulkin will have oversight over the system that employs over 300,000 people who work in the health system.



Prior to being nominated by President Obama and being confirmed by the United States Senate as Under Secretary of Health, Dr. Shulkin served in numerous chief executive roles including serving as President at Morristown Medical Center, Goryeb Children's Hospital, and Atlantic Rehabilitation Institute, and the Atlantic Health System Accountable Care Organization. Dr. Shulkin also previously served as President and CEO of Beth Israel Medical Center in New York City. Dr. Shulkin has held numerous physician leadership roles including the Chief Medical Officer of the University of Pennsylvania Health System, the Hospital of the University of Pennsylvania, Temple University Hospital, and the Medical College of Pennsylvania Hospital. Dr. Shulkin has also held academic positions including the Chairman of Medicine and Vice Dean at Drexel University School of Medicine. As an entrepreneur, Dr. Shulkin founded and served as the Chairman and CEO of DoctorQuality one of the first consumer orientated sources of information for quality and safety in healthcare.

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

Over his career Dr. Shulkin has been named as one of the Top 100 Physician Leaders of Hospitals and Health Systems by Becker's Hospital Review and one of the "50 Most Influential Physician Executives in the Country" by Modern Healthcare and Modern Physician. He has also previously been named, "One Hundred Most Influential People in American Healthcare" by Modern Healthcare.



Department of Veterans Affairs
Senior Executive Biography

Ronald E. Walters
Interim Under Secretary for Memorial Affairs

Ronald E. Walters was named the Interim Under Secretary for Memorial Affairs, effective June 23, 2014. Mr. Walters was Principal Deputy Under Secretary for Memorial Affairs from January 2009 and Deputy Under Secretary for Finance and Planning and Chief Financial Officer for the National Cemetery Administration (NCA), from July 2006.



As Interim Under Secretary, he leads 133 National Cemeteries in providing dignified burial services for military Veterans and eligible family members. His responsibilities also include: maintaining the cemeteries as national shrines; land acquisition, design, construction, and other activities relating to the establishment of new national cemeteries; overseeing other memorial programs to honor the service of deceased Veterans, including provision of headstones, markers, medallions and Presidential Memorial Certificates; and administering federal grants to help states, territories and tribal governments establish Veterans cemeteries.

In his previous position, Mr. Walters was responsible for the successful implementation of key legislative mandates including the Chief Financial Officers (CFO) Act and the Government Performance and Results Act (GPRA) within NCA. He represented NCA at congressional hearings, in briefings with members of Congress and their staff, Veterans Service Organizations (VSOs), the Office of Management and Budget (OMB), and advisory committees and other interested groups.

He began his career with the Department of Veterans Affairs (VA) in 1985 as a Budget Analyst in the Controller's office and held various other management positions during his tenure. In October 2003, he accepted a position as the Associate Chief Financial Officer for Budget and Planning in the Office of Personnel Management. He held that position until joining NCA in 2006.

Mr. Walters received a Ph.D. in Political Science from Johns Hopkins University (JHU) in 2002 and a Masters in Public Administration from George Washington University in 1986. He graduated magna cum laude and Phi Beta Kappa with a Bachelor of Arts from Georgetown University in 1984. He was a Rhodes Scholar finalist in Virginia and received a Presidential Rank Award in 2010. He was a finalist for the 2014 Samuel J. Heyman Service to America Medal in the Management Excellence category. Mr. Walters has taught courses in American Government at JHU and Montgomery College. He is currently an instructor at the University of Maryland (Baltimore County).

Updated October 2015

CARE IN THE COMMUNITY

Mr. DENT. Thank you, Secretary McDonald. Mr. Secretary, as we discussed, in my view the VA would serve veterans better if it contracted more with existing private providers, rather than try to establish an in-house capacity for medical treatment, when VA may have problems getting adequate staffing or is located far away from where the veterans live.

The RAND Corporation assessment of VA care that was mandated by the Choice Act found that through 2019, the demand for VA services may outpace supply. But from 2020 onward, demand for VA care will level off or decline.

With this changing landscape for likely demand for VA services, does it really make sense to continue to build up VA infrastructure capacity and staffing? You know, by the time you have built the facilities and hired all the doctors and other medical staff and allied professionals, the hospital is maybe half empty and staff underused.

The RAND assessment noted a problem with the way that VA is approaching its future plans for providing care. It seems like VA has chosen the route of increasing everything, from both community care and VA direct care, without a long-term strategy defining what the balance of these approaches should be and whether the VA's role is predominantly the provider of or the payor for medical services.

Do you have any thoughts on that, or are you waiting for Congress to mandate the strategy?

Secretary McDONALD. No, Mr. Chairman, we are not waiting for Congress. Our vision of a long-term VA system is an optimal system of private sector and public sector partnerships. We currently partner with Department of Defense, Indian Health Service, Alaskan Native Health Service, our medical school affiliates, which is a system that Omar Bradley set up in 1946 and has served us very well, as well as private sector partners, like TriWest and Health Net.

I am going to ask David to talk a little bit about that in a minute, but I want to make sure I deal with one thing, and that is demand. While that study did say that demand would wax or wane for a period of time, we would go down for a period of time, it is going to go back up.

The problems in 2014 that created the crisis for the VA were not because of the wars in Afghanistan and Iraq. They were because of the aging of the Vietnam veteran, 2.5 million veterans over the age of 65 in 1975, 10 million veterans over the age of 65 in 2017, a five times increase.

VA is the canary in the coalmine. We see the problems in American medicine before American medicine sees them. The aging of the Vietnam-era veteran is what created that demand.

So, my point is, if we don't build the capability today that we are going to need 40 years from now, when the Afghanistan and Iraqi veterans need the VA, when they turn 65, or around that time, we are not gonna have it.

So we need to make sure we build this optimum network, in order to serve veterans, long-term.

Dr. SHULKIN. Excellent question. That is exactly what we spend a lot of time thinking about. VA does work with the RAND Corporation very closely, but we have a very sophisticated model for projecting enrollment, called the Veterans Enrollee Projection Model.

And, basically, what it says is, your numbers are correct, but what the secretary's referring to is younger veterans coming out of the recent conflicts, actually, are more service connected and have much more intensity, in terms of their needs of services.

So our projections aren't necessarily for larger numbers of veterans entering the system. It stays relatively flat, increasing up to about 1 percent over the next 5 years. But the number of services that we project that they are gonna require, that they need, actually goes up.

It does change the configuration of the VA health care system. We agree. We think we are gonna need less inpatient beds, but greater ambulatory, or outpatient, capacity. I think, finally, we recognize VA can't do this alone. We are embracing working with the private sector, working with the local communities.

That is why we submitted, in October of this year, the new Veterans Choice plan, on a way that, we believe, we should be working with the private sector for decades to come.

SERVICE-CONNECTED ISSUES

Mr. DENT. A quick followup on that. I do understand the intensity of the returning veterans where their issues are, obviously, very great. System-wide, what percentage of the veterans being served in the VA health system, particularly at the hospitals, are being treated for service-connected issues.

It is my understanding, in the hospitals in my area, about 40 percent, roughly, 40 percent of those being served are service-connected. And it just speaks to the issue of, given the intensity of these injuries, that the VA must become more specialized, and that, you know, a lot of oncology services, cardiothoracic, can clearly be done in the community very effectively.

And we need to address that. Any suggestions?

Dr. SHULKIN. Yes. As I am sure most of the members know, we have eight priority groups for veterans. And I think the number that you are talking about, but unless the Secretary or somebody else has the specific numbers, we would be glad to get them to you.

[The information follows:]

Priority Groups

Today's Veterans have a comprehensive medical benefits package, which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are readily available to all enrolled Veterans. Complementing the expansion of benefits and improved access is our ongoing commitment to providing the very best in quality health care service to our patients when they are needed during that enrollment period regardless of the treatment program or the location.

Priority Group 1

- Veterans with VA-rated service-connected disabilities 50% or more disabling
- Veterans determined by VA to be unemployable due to service-connected conditions

Priority Group 2

- Veterans with VA-rated service-connected disabilities 30% or 40% disabling

Priority Group 3

- Veterans who are Former Prisoners of War (POWs)
- Veterans awarded a Purple Heart medal
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with VA-rated service-connected disabilities 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
- Veterans awarded the Medal Of Honor (MOH)

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits from VA
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

- Nonservice-connected Veterans and noncompensable service-connected Veterans rated 0% disabled by VA with annual income below the VA's and geographically (based on your resident zip code) adjusted income limits
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid programs

Priority Group 6

- Compensable 0% service-connected Veterans
- Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Project 112/SHAD participants

- Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975
- Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998
- *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987
- Veterans who served in a theater of combat operations after November 11, 1998 as follows:
 - Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge.
 - **Combat Veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act.

Note: At the end of this enhanced enrollment priority group placement time period Veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.

***Note:** While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.

***Note:** While eligible for PG 6; due to system limitations, Veterans will be manually assigned to Priority Group 8c, yet eligible for the enhance benefits

Priority Group 7

- Veterans with gross household income below the geographically-adjusted income limits (GMT) for their resident location and who agree to pay copays

Priority Group 8

- Veterans with gross household income above the VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays

Veterans eligible for enrollment:

Noncompensable 0% service-connected:

- Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status
- Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less

Nonservice-connected and:

- Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status
- Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less

Veterans not eligible for enrollment:

Veterans not meeting the criteria above:

- Subpriority e: Noncompensable 0% service-connected (eligible for care of their SC condition only)
- Subpriority g: Nonservice-connected

Dr. SHULKIN. But I think about the percent you are talking about are in the highest level service level, 100 percent connected. But throughout the various priority levels, veterans have percentages of their problems that are related to service-connected issues.

So we are providing the type of care that is necessary, depending upon the level of service connectedness. And that depends on their benefits how much VA pays for and how much the veteran's responsible for.

CARE IN THE COMMUNITY

Secretary McDONALD. Mr. Chairman, if I could, I just want to add that VA was already using community care prior to the Choice Act. In fact, when the crisis occurred, we provided about 7 million more appointments, versus the previous year. Four and a half million of those were care in the community, and most of those were prior to the Choice Act.

So we are believers in using care in the community. And we need to, as David said, because otherwise we won't be able to meet the demand. And one of the things we have seen recently is, as we provide better care, the demand for that care increases.

Mr. DENT. Thank you. Well, I won't belabor the point, but, you know, we also have to realign the incentives to make it easier for people to go out into the community. The incentives aren't quite right. But let's go to our friend and Ranking Member, Mr. Bishop.

UNDERFUNDED PRIORITIES

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

Mr. Secretary, as you know, you are requesting an additional \$1.7 billion for medical care in 2017. I understand that budgeting 2 years in advance is tough and that priorities can change, but in fiscal year 2017, the second bite of the apple, you requested an additional \$840 million for hepatitis C, bringing the total to \$1.5 billion.

Hepatitis C is a known priority. So why was it short-changed in the advance? You also included non-recurring maintenance in the second bite, which to me looks like that number was used to pay for Denver. And I noticed that VistA Evolution is reduced by \$40 million.

My concern, now, is that the VA is purposefully underfunding priorities in the advance and using the second bit to fix problems that should have been budgeted for.

Can you explain how you set those priorities in the advance request and what metrics you are using for the second bite, and whether or not we will continue to see the second bit grow each fiscal year?

Secretary McDONALD. Thank you, Ranking Member Bishop. That is a very good question. I think hepatitis C is a case in point. It shows the difficulty of trying to budget. You may recall last year we came back to our authorizing committees for permission to move money from the Choice Act budget to our internal budget, because of the invention of a drug that we didn't predict.

It is very hard to predict the invention of a drug 2 or 3 years before the budget actually becomes actual. And, in the case of hep-

atitis C, we have had a plan to virtually solve hepatitis C for veterans within 5 years.

Now, because of a new drug that has come on the market, some more competitive pricing, David and I have been talking about how do we accelerate that and actually cure the disease for all of our veterans before that.

But what we have been asking for and what we would like to have is some flexibility to move money from one account to another, so we can get after these things. Certainly, I can ask LaVerne to talk about, in terms of NRM—let me talk about NRM.

As you know, 60 percent of our buildings are over 50 years old. NRM becomes a very big issue for us. You were talking about an increase of women veterans. Many of our buildings were built during the time when single-gender restrooms were acceptable.

We even have some of our hospitals that have communal living. They don't even have single rooms or double rooms. And, in fact, David, you have the numbers on that. What are the numbers for that?

Dr. SHULKIN. We have over 1000 rooms in the VA system that have three or four beds in a single room that share a bathroom.

CHANGES IN PLAN FOR ELECTRONIC HEALTH RECORD

Secretary McDONALD. And for an all-volunteer Army, when you are trying to attract an all-volunteer force, when you are trying to attract people to that armed forces, to have those kinds of standards that are archaic are no longer acceptable, I think. You want to talk about VistA?

Ms. COUNCIL. Sure. The reduction in VistA was really driven around the fact that this evolution, which was created in 2014, was really to deliver modernized VistA capabilities. For 2017, the budget for VA was focused on investments to further expand our interoperability with DOD and the community providers that we now have to interface with.

We continue the development of our enterprise health care platform, primarily around some of the clinical needs that we need to address, and making sure that the JLV, or what we call our Joint Legacy Viewer, would be in place, in order to meet out NDAA expectations from 2014.

What Dr. Shulkin and I decided to do, after having a full review of the business case of VistA, was to focus this team primarily on those things that would enable that interoperability and also enable some of the clinical needs that were needed.

But we also wanted to take a step back and look at what we really needed to have on an EHR, as well as a health care system, do. And, as you mentioned here already, there is multiple needs that have occurred that are different than those that were even looked at in 2014 around women's health, around the area of the Internet of Things, which is now creating a very different point of view of how we deal with health care.

But, also, how do we manage choice and how do we manage care in the community? So those are the things that are just the VistA cost, but they also will come back when we come back with the new strategy.

Mr. BISHOP. Chairman, may I ask a follow up quickly?

Mr. DENT. Please.

VA AND DOD INTEROPERABILITY

Mr. BISHOP. It is my understanding that, as you indicated, that VistA modernization has now taken a pause, but that should not affect the interoperability, isn't that correct?

Ms. COUNCIL. It does not affect interoperability. In fact, we are on schedule to define a clear interoperability with DOD here in March and have an electronic fee capability between eHMP and the DOD system by August of this year.

Mr. BISHOP. Has the money, then, that we appropriated for modernization of VistA been a complete waste? And what are your plans moving forward? Explain how this will not affect the interoperability.

Ms. COUNCIL. Actually, the interoperability will be met. We will achieve the needs that we have with DOD and increasing interoperability of the data between ourselves and themselves.

In addition, beyond the EHR modernization that was part of VistA, it actually included some critical investments in systems and infrastructure, supporting not only interoperability, but networking, infrastructure sustainment, a number of the continuation of some of the legacy capabilities and upgrading those to ensure they were secure and that we have security put around them that was appropriate, as well as ensuring that we had clinical terminology standardization, which is a key part of being able to have care in the community or interface with care outside of the VA.

So the dollars that were in the VistA evolution were primarily focused on not only interoperability, but, also, the sustainability of VistA and allowing it to grow.

Secretary McDONALD. Mr. Ranking Member, I just want to remember when we were together at Martin Army Hospital in Columbus. We are going to be using 18 specialists from Martin Army Hospital to treat veterans. That kind of use of DOD and VA facilities simultaneously could not be done without interoperability. So that is critical to our success.

Ms. COUNCIL. And I think, one side note, if I may, the JLV is at a point of a little over 35,000 users, which is well ahead of where we had planned on it being used. So we are well ahead of our goal there. And it is available across the enterprise and being used by, at this point, well over 35,000 doctors.

Mr. DENT. Thank you.

At this time, I would like to recognize the chairman of the full committee, Mr. Rogers, for his questions.

Chairman ROGERS. To follow up on that line of questioning, some of you heard me tell this, but it illustrates the point better than I can describe it for you. A young man came to me a few years ago, in my office, a constituent, a veteran. Had been injured in Afghanistan.

I believe he lost one eye. The other eye was severely damaged, but he was taken to the hospital in Germany. They operated. He came home as a veteran. The good eye began to deteriorate, so he goes to the VA hospital in Lexington.

And they say, "We can't do anything for you. We can't get your records from the hospital in Germany that DOD has. We just don't

have access to that system. I am sorry, but we don't want to operate, because we are not sure what is in there that they did in Germany." So they turned him away, and he goes blind.

That illustrates the point that Mr. Sanford Bishop has described better than I can tell you. Now, this subcommittee began on a warpath on that very subject and to try to force DOD and VA to merge systems, at least become interoperable. I forgot what year that was. It is probably 7 or 8 years ago.

Mr. DENT. At least.

Chairman ROGERS. At least. And we have given you money. Money is no problem. But I just fail to see how we can not do this quickly. I have watched the demonstration that we had a year ago or so, and it looked like we were headed the right way.

But I am told now that DOD has awarded a \$4.3 billion contract to a company called Leidos, Inc., for a new electronic health record. What does that do to this move toward interoperability between VA and DOD?

Secretary McDONALD. First—

Chairman ROGERS. Simple words. Simple language.

Secretary McDONALD. Sure. First of all, I think the situation you described, that young veteran, happened several years ago, would not happen today. We, as LaVerne said, we do have the capability. We do have the Joint Viewer. We do have DOD VA facilities all over the country, San Antonio, Chicago, and Lovell. The chair, the ranking member and I were together at Martin Army Hospital.

So the situation you described strikes me that that would not happen today.

Ms. COUNCIL. No, no. In fact, to put it at rest, as EHR, as you think about it, the interoperability is really around the data, and the ability to view the data, the doctor to leverage the data and to understand the context of what was going on with the particular patient at the time, so we can be clear about what we can do for them.

This evolution program has continued to build on the JLV and the next generation electronic capabilities called eHMP. eHMP is really what we are leveraging to pull the DOD product, and align it with our product, as an integrated grouping.

So our data is fully interoperable, and our data will be able to fully claim that in August of this year, as we had scheduled and planned. In particular, by the end of this month, we will be able to say that we are fully mapped to the same level of data with DOD and that this information is shared through that JLV.

As I mentioned, with well over 35,000 users, we will be well ahead of our goal. But anytime anyone needs a record, at this point, they can get it, as it relates to that veteran. And I understand how that veteran was treated outside of the VA.

Chairman ROGERS. And you would be able to find records of past treatments?

Ms. COUNCIL. Yes. Yes, sir.

Chairman ROGERS. Well, you know, it is just absolutely insane for us not to have a system that links veterans' benefits programs, health programs, with what happened in the active military.

Ms. COUNCIL. Yes.

Chairman ROGERS. That is elementary.

Ms. COUNCIL. You are correct. And we are, actually, going one step further by looking at all data related to the veteran. We have an ability to look at those that are in active service today.

We utilize that information to understand what we need to do on our benefits, and we are looking holistically at the veteran, not just at health, but all the benefits that they have rights to and ensure that we have the right data at the right time, bringing it together with e.gov, but, also, bringing ourselves into the 21st Century with enterprise data management capability.

ALTERNATIVE TO VISTA

Chairman ROGERS. You were working to modernize your existing Vista record, DOD contracting for a new one. But I understand now, if I hear you right, that you are reconsidering modernizing Vista and thinking about acquiring an off-the-shelf product. Is that right or wrong?

Ms. COUNCIL. Sir, we are, actually, Dr. Shulkin and myself, were not here during that time of that decision. And we took a step that said we were gonna be good stewards of the use of those dollars.

We did a business case around Vista. Based on that business case, our question was could we enable the future around women's health, around care in the community, ensuring the security, and also increasing the mobility that is required within medical care today.

When we look at the issue, we felt that we needed to take a step back and get the team's continued focus on interoperability, but, also, ask ourselves a question. What will it take to support the needs in the future, and what will it take for us to have a secure, capable health care capability that we can grow upon, not just in EHR.

And, so, we are in the current process of looking at what that is. It could be an upgrade to Vista. It could be an alignment to use it as the EHR and figure out the best of breed processes to reach those other venues.

Chairman ROGERS. Look. We have been at this 10 years. We have been at this 10 years. We have given you billions of dollars. And I am hearing muckity muck here. I don't know what you are saying. Apparently, you are saying you have not made your mind up yet about whether to replace the Vista system with something off-the-shelf. Is that right or wrong? Yes or no?

Ms. COUNCIL. We have not made our minds up, sir. And, now, let me tell you why. I think it is—

Chairman ROGERS. Be brief. Be right to the point.

Ms. COUNCIL. I am going to be right to the point. The fact is we need to ensure that we have laid out the plan and strategy so that everyone can understand exactly what we are doing and why we are doing it.

When we came into these roles, we didn't have that strategy laid out. And it is important, if we are gonna be able to say that we are good stewards of those millions of dollars, that we act like it and put the plan there. And that is what we are going to do.

And it is not going to stop anything that is currently being done. Everything that is being done is not being done in a wasteful manner. It is being done as expected and as promised. But, we are,

also, gonna lay out a format that is gonna allow you to understand exactly what IT is spending their dollars on and what VHA is doing.

Chairman ROGERS. Well, the Secretary tells us that what happened to my young man would not happen today. Is that right, Mr. Secretary?

Secretary McDONALD. Yes, sir. That is what I said.

Chairman ROGERS. But I am hearing that you are having second thoughts about the system that you are headed toward here. Is that right?

Ms. COUNCIL. No, sir. That is not what I am saying.

Chairman ROGERS. Dr. Shulkin, do you have an idea about this?

Dr. SHULKIN. Yes, I do. First of all, I completely agree with the Secretary. I, actually, now practice in the VA health system, use the VistA record. I completely agree. This would not happen. We can absolutely get records from the DOD using the Joint Viewer. That is being done today. Thirty-five thousand clinicians are using that.

We are moving full ahead to make sure that VistA is an optimized system. As Ms. Council said, we are not slowing down anything on VistA. We have millions of dollars to enhance us.

But I think what Ms. Council's saying is we have the responsibility—technology has changed so much, we have the responsibility to lay out a plan to make sure that the system that we are using now is gonna meet the needs of veterans for the future.

And that is what we are doing. Not slowing down. We are using VistA. It gets better every day. But we are looking at this, once again. And I think that is why we came into these roles, to make sure that this is the right plan for veterans and the right plan for the American public.

Chairman ROGERS. Well, deadline is 2018. There will be no further excuses after that.

Ms. COUNCIL. No problem.

Chairman ROGERS. This has taken altogether too long. I know it is complicated, and I know the Army, the active military have their own systems. You have had your own systems. Apparently, we have got sort of an intermediary thing that can decipher both, at the moment.

But I am not peaceful about this. I am restless, because the young people that we are sending over there deserve that we not let bureaucracy stand in the way of their health.

Secretary McDONALD. We agree with you, Mr. Chairman. The three people sitting in front of you here are not from bureaucracy, they are from the private sector. LaVerne was the CIO at Johnson & Johnson and at Dell.

But what we have to deal with, too, is the comments Chairman Dent made about interoperability with the private sector. Remember, we are going to be sending more and more veterans to the private sector for their care. And we need to make sure that interoperability that we have been working on for DOD is similar with the private sector. And that is a big change.

But we will stay on this. We will brief you whenever you would like and make sure that we take advantage of the committee's wisdom, as we move forward.

Chairman ROGERS. Thank you. Keep us posted.

Secretary McDONALD. Yes, sir.

Chairman ROGERS. Big time importance to us.

Secretary McDONALD. I understand your frustration. And we will keep you posted.

Chairman ROGERS. Thank you.

Mr. DENT. OK. Thank you, Mr. Chairman.

At this time, I would like to recognize the ranking member of the full committee, Mrs. Lowey.

Mrs. LOWEY. Thank you, Mr. Chairman, and thank you, Mr. Secretary.

Before I proceed, I just want to say this has been a bipartisan concern of this committee. And I cannot tell you how many hearings, how many closed sessions, and I know of your past career at Proctor & Gamble. And maybe you can share with us, at another time, the same kind of confusions the private sector has.

But, frankly, whether you are a Democrat or Republican, we have not been able to understand why interoperability has been so difficult. So I thank you. We look forward to your success, and I want to proceed on another question that I have been concerned about.

FEMALE VETERANS HEALTHCARE

I know that the VA facilities have, traditionally, treated the needs of men. But we all know that the VA needs to adjust to the 21st Century and make sure it meets the needs of female veterans.

I have mentioned to you, Mr. Secretary, the story of one of my constituents, who went to the VA medical facility in her third trimester of pregnancy, only to be told that they had never seen a pregnant vet there before and sent her away without the necessary referral. It is 2016 and the VA, as you and I would agree, should not be an unwelcome environment for female veterans.

We need a bigger discussion on the types of care offered by the VA health system, Mr. Secretary. How inclusive do you see the VA health system in the future? To what degree do you feel the VA should offer non-service connected health care?

And your budget request acknowledges the unique needs of women's health care and the ongoing efforts to improve female veterans' health, but what efforts are actually being made, specifically, to enhance access to obstetric and gynecological care for female veterans?

Secretary McDONALD. Let me first say, Ranking Member Lowey, we agree with you that the increasing veteran population is part of our transformation of VA. We simply have to do a better job.

You know, since 2000, the number of women veterans seeking VA services has doubled from 160,000 to over 447,000. That is a huge, huge sea change. And we have to do a better job with women. We have designated women's health providers at every one of our sites.

We have put in place women's clinics at many of our sites, but not all. We talked about the importance of our non-recurring maintenance budget. A hundred percent of our medical centers and 94 percent of our community-based outpatient clinics have at least one designated women's health provider.

We trained over 2,400 providers in women's health, to ensure that they could interface with women veterans. We have women's veteran program managers in our sites. We have maternity care coordinators. And we need to hire more OB/GYNs. We need to think about daycare.

And an important thing, I think, for the committee is the fact that a veteran who was injured in combat and is unable to procreate, can get in vitro fertilization service from DOD, but not from VA. And that is a matter of law.

David, do you want to—

Dr. SHULKIN. Yes. I just want to very briefly add, this is a great connection, Congresswoman, between the Chairman's comments, as well. So our enrollee projections show an increase in women veterans. So you are absolutely correct.

We are laser focused on increasing services to women veterans. But we don't believe VA should do it all. So we are very focused on primary care and mental health services for women.

We are growing our women-focused clinics in all of our VA medical centers and training more physicians and gynecologists to be there. But let's take maternity care that you mentioned.

We don't believe it makes sense for VA to develop maternity services in our VA hospitals, when we have great community hospitals in our most of our communities that, frankly, do a lot more maternity care than VA does.

So that is where we are developing those linkages. And those community hospitals have neonatal intensive care units that you need for high-risk women and deliveries. So this is a great example, focusing in on the services that women veterans need in VA, but working with the community for maternity services and neonatal intensive care.

Mrs. LOWEY. Well, I appreciate that. In the last 58 seconds I have, we know that female veterans are six times more likely to commit suicide than women in the general population. And female veterans between the ages of 18 to 29 are 12 times more likely to commit suicide than their male counterparts.

So I appreciate your views, and I look forward to hearing about the progress that is being made.

Thank you, Mr. Chairman.

Mr. DENT. I thank the ranking member.

And I am glad to hear, Dr. Shulkin, what you said, too, about we really ought not be developing that kind of capacity within the VA system when there are so many good opportunities for women in the community, as it relates to OB/GYN services. So, thank you for pointing that out.

I would like to recognize Mr. Valadao, at this time, for 5 minutes.

Mr. VALADAO. Thank you, Mr. Chairman.

APPEALS CASE—LOS ANGELES AND OAKLAND REGIONAL OFFICE

Thank you, Secretary, and guests, for your time today. My first question, my office provides Central Valley veterans services to help them navigate the VA. Last week, a constituent in my office found out that a videoconference request to appeal his case with the VBA was simply lost in the cracks.

During our attempt to help him, we could not get a hold of anyone at the LA Regional Office, where the case was assigned. Instead, we had to contact the Oakland office, which has always been responsive.

They told us that the LA office had his request, from a year ago, but failed to attach it to his file. My constituent has now been waiting for over a year and now must wait even longer. And this is not an isolated incident and shows a breakdown in recordkeeping.

There is also discrepancy in the quality of service between regional offices. In the time that I discussed this case with the IG, the VA has worked quickly to help this constituent out. But cases like this shouldn't require Congressional action to get the problem solved.

Mr. Pummill, why aren't there systems in place to make sure requests like this don't fall through the cracks? And how can the VA better utilize best practices between regional offices to make sure quality of service is consistent?

Mr. PUMMILL. We are doing exactly that—when the Secretary did his opening statement. We have a problem with our appeals process right now. The current appeals process that we have, it is set in law. It is lengthy. It is complex. It is just not fair. It is not fair to veterans, at all.

One of the things that we have done in the last year with the money that we got for fiscal year 2016 and the money we get for fiscal year 2017 is beef up some of the areas, other than the claims area. One of those areas is our call centers, the appeals centers, the non-rating area [Off mike], the Los Angeles office and the Oakland office.

The Oakland office, the 15 people we put there are already trained. And they are full up right now. The Los Angeles office are a little bit newer. To make sure that the—the same level across the offices, we are actually using the MyVA and the Leaders Developing Leaders program that the Secretary brought in—here at Lansdowne the last 2 days. Part of that meeting, I brought them all in and we had discussions on where we are going, what is happening, how to take better care of veterans and how to get a better consistency when we are dealing with veterans.

We are bringing in all—I am sorry.

Mr. VALADAO. That is just a really long answer. I am sorry. We have got a lot of questions we want to ask. But—

Mr. PUMMILL. OK. Yes. Yes.

Mr. VALADAO. But as far as, you said the process is part of law. Do you have any recommendations or bill ideas that we can do to change that?

Mr. PUMMILL. Yes, we do. We have some ideas right now. And next week, we are bringing in the veterans' service offices and the state veterans service organizations. They are going to meet with us, and, as a group, we are going to sit down and come up with a recommendation that we can bring to you—

Mr. VALADAO. I appreciate that.

Mr. PUMMILL [continuing]. To change the law, so that we can do a better job.

Mr. VALADAO. And, then, as far as when you have a regional office, like that with Los Angeles, when they are not responsive to Congressional inquiries, what is the process to—are folks fired?

ACCOUNTABILITY AND PERFORMANCE PLAN

I mean, do we do anything to these people for not responding when we are trying to take care of our constituents, the veterans in our district? Is there a punishment of any sort? Because we always hear about the bonuses that are paid out, but I am curious if there is a punishment when someone—

Secretary McDONALD. As I said in my prepared statement, bonuses are actually down across the VA. That is purposeful, because we are trying to match performance with reward. But, yes, if you can let us know.

We, what we have done, since I have become Secretary and Sloan Gibson has become Deputy Secretary, is we have put customer service in everybody's performance plan. And this is bad customer service. It should not happen. So, please, let us know about it.

VA SCHEDULING PRACTICES

Mr. VALADAO. OK. And we will. All right. And, then, my next one is, it is becoming clear that a major cause of the VA's ongoing backlog is the result of bad scheduling practices.

In an October 2014 report, the Northern Virginia Technology Council found that the VA's current scheduling procedures are insufficient and unable to meet the needs of America's veterans.

A recent GAO report on wait times confirmed this and showed even more problems with scheduling, especially for mental health care. Last week, during a hearing before this committee, Deputy IG for the VA Linda Halliday stated that the VA needed to tighten up its scheduling practices.

Secretary McDonald, can you talk about the problems you see with the scheduling process and how is this delaying care for America's veterans? And I, also, understand that the VA has undertaken an expensive project to upgrade their computing schedule software.

How are you working to better the human element of schedulers working with our veterans?

Secretary McDONALD. The majority of the problems that we have had with scheduling deal with, really, two—well, three things. Number one is the scheduling system, itself, dates to 1985. Let me show you a picture of it.

The picture on your left is the current scheduling system. It dates to 1985. This picture does it too much justice. It is, actually, green screen. So imagine this screen being green screen. It looks like MS-DOS.

Imagine being a scheduler at VA trying to do scheduling with this. And you can't move from one window to the other. In other words, when you go on one clinic, you are stuck on that one clinic. You can't get to another clinic.

This is the change, over on this side, that we have put in place, which optimizes the user interface. And we can talk about that.

Mr. VALADAO. When did you put that in place?

Secretary MCDONALD. Our very first clinic in Asheville, North Carolina, our women's health clinic started to use it in January. It is about to go into New York Harbor and Salt Lake City, and then, in April, a national rollout.

Mr. VALADAO. OK.

Secretary MCDONALD. The second part of that is, of course, training the employees. The number of IG investigations that we have done on scheduling throughout all of our facilities found that the number one issue was not people deliberately trying to harm veterans, of course. It was untrained employees.

And that is why we have invested in the training. That is why we had our people off-site. And we have really put time in investing in training. The third point is a lack of providers. And that is why we are hired over 1,400 more doctors, over 2,300 more nurses.

We just didn't have enough people to serve veterans. So that should make the scheduling system much better.

Mr. VALADAO. Thank you.

Secretary MCDONALD. At this time, I would like to recognize the gentlelady from California, Ms. Lee, for 5 minutes.

OAKLAND REGIONAL OFFICE AND ACCOUNTABILITY

Ms. LEE. Thank you, very much. Good morning. Thank you, Mr. Secretary. Thank all of you for being here today. Let me ask you a few questions, as quickly as I can.

First of all, in January 2016, the OIG report found that the Oakland Regional Office continues to have, and let me just quote from this report, "significant delays in processing claims and that the management did not provide the oversight needed to ensure timely and accurate processing of informal claims and included 1,308 identified back in March of 2015."

And, as a result, one of the recommendations is that the regional director provide training to staff on proper informal claims processing procedures and conduct a complete view of the remaining 1,248 informal claims. This has been going on and on and on.

And we keep hearing responses that really don't measure up to what is actually taking place. So I want to find out how are you gonna hold the Oakland Regional Office accountable?

Second question—

Secretary MCDONALD. Well—

Ms. LEE. OK.

Secretary MCDONALD. Let me answer this first.

Ms. LEE. OK. OK.

Secretary MCDONALD. We did hold the regional office accountable. We have a new leader there, Julie Boor. That report, that IG report, was about a couple of years old, maybe more than a couple of years old.

Let me ask Danny to comment on what the Oakland Regional Office is doing today, because we have changed the leadership. We have improved the training. And I think the Oakland Regional Office, today, is performing as well, if not better, than our national average.

Mr. PUMMILL. They are. Oakland is now providing better than national average. Julie's done—okay—we actually stood down the entire office for a retraining—since Julie has got there, there has

been a huge turnaround, a 90 percent improvement in her work inside of the RO.

Ms. LEE. OK. We are going to follow up with you on that, at least.

Mr. PUMMILL. You are welcome to come down anytime.

Ms. LEE. Yes.

Mr. PUMMILL. She would love to show you around.

LESS THAN HONORABLE DISCHARGE WITH PTSD

Ms. LEE. OK. Second question. And thank you, very much, for that. The issue around PTSD, this was reporting in New York Times last week. And I want to know a little bit more about that, in terms of the vets with PTSD receiving less than honorable discharge from the military, as a result of minor infractions from the military and obstacles with those seeking an upgrade on their discharge.

Of course, I am concerned—I mentioned this at another hearing—that the burden of proof for PTSD, it continues to be on the veteran, rather than on the VA or the military, and that the board is responsible for considering such appeals don't lack transparency and they are not staffed properly.

So, in terms of this effort, those with past PTSD claims that were denied, how are you addressing that and what are you doing?

Secretary McDONALD. Of course, the status of someone's discharge comes from the Department of Defense. And there is a mechanism in the Department of Defense to ask for a review.

But this is the reason that we thought strategic partnerships were so important, our fifth MyVA strategy. There are about 15 percent, 15 to 20 percent of veterans who have less than honorable discharges. By law, we are not allowed to serve those veterans.

So we need strategic partners, people in the community. I visited an organization in Boston called Home Base. It is funded by the Boston Red Sox Foundation. They are a strategic partner of ours in the Boston area.

So when we find a veteran who has bad paper, what we call bad paper, a less than honorable discharge, we can send them to Home Base, and they will be treated just like they would as if—

Ms. LEE. OK. But I am talking about upgrading their discharge, if they were denied.

Secretary McDONALD. That is a Department of Defense job.

MINORITY AND WOMEN-OWNED CONTRACTORS

Ms. LEE. That is DOD. OK. We will talk to DOD about this, then. Let me ask you, then, about your expenditures, in terms of contracting. You spend a lot of money. And I would just like a breakdown of your minority and women-owned contractors, percentage-wise, and how you break that down and would like to review that for this committee.

Secretary McDONALD. Great.

[The information follows:]

In Fiscal Year 2015, VA obligated \$20.084 billion in net contract dollars for goods and services. Of this amount, \$1.498 billion (7.5%) was with Small Disadvantaged Businesses, and \$594 million (3.0%) was with Women-Owned Small Businesses.

In terms of the number of contractors (measured by the number of unique DUNS numbers), VA did business with 20,039 contractors in FY 2015. Of these, 3,189 (15.9%) were Small Disadvantaged Businesses and 2,430 (12.1%) were Women-Owned Small Businesses.

Source: VA analysis of data from the Federal Procurement Data System.

CIVILIAN POLICE TRAINING

Ms. LEE. And the other question, or point, I want to raise, because I am gonna see how we can work on this, I want to look at our veterans who are returning into civilian life, entering into civilian police departments.

I want to look at the training, how you train them for that transition from war to working in civilian police departments. I have heard many times, over and over again, that many of the issues we have in the community, as it relates to a lot of the distrust between communities and the police, a lot of the police misconduct could be related to improper training with veterans who come directly into the police force, who have been in Iraq or Afghanistan.

Secretary McDONALD. I, honestly, don't think that characterization is fair. We have something called a Transition Assistance Program. It is roughly 120 days, or more, before someone departs the military. We put on an event at the post, the commanding officer, general, or admiral helps us.

At that event, we get people signed up for their benefits. We explain what VA does. We also have a job fair, and we get them signed up for jobs. And it has been my experience through that, although this is anecdotal—I don't have any data yet—that, actually, the cities of the United States, many of the mayors want to hire veterans—

Ms. LEE. No, no, no. I am not mischaracterizing this. I am just saying that it is my understanding, from talking to many, that the training and the transition has not been adequate, in terms of the skills and in terms of what is needed to work in the police force in a community in the United States versus coming straight—you know, versus in Iraq or Afghanistan.

Secretary McDONALD. I think the transition we are doing today is better than ever before. We have 250,000 service members leaving and what we want to make sure is that those individuals have jobs and are trained for those jobs before they leave the military. [The information follows:]

No, VBA does not provide specific training to transitioning Servicemembers to work in civilian police forces. However, VBA does provide Servicemembers with tools to build their resume. They can use the Military Skills Translator in the Veteran Employment Center™ (on vets.gov) to find skills related to their military occupational specialty.

VBA notes that under its VR&E program, Veterans may choose to attend a number of approved programs in law enforcement, but nothing that specifically focuses on just transitioning Servicemembers. As part of that, VBA must make sure that any VR&E program a Servicemember or Veteran chooses is consistent with his or her service-connected disability and any resulting limitations. Under VBA's GI Bill programs, there are numerous approved programs in law enforcement (such as on-the-job training for attending a police academy), but they do not specifically focus on transition from the military to civilian police force as part of the required curriculum. There may be some programs that do have such a focus; however, VBA is not aware of any because such program would be "Veteran only," and a State Approving Agency would not approve that. VBA does not have a list of non-approvable and/or non-approved programs under the GI Bill.

Ms. LEE. Sure. And I just want to make sure they are trained properly.

Secretary McDONALD. I understand.

Ms. LEE. And that is what I would like to get information on. Thank you.

Mr. DENT. Thank you. Thank you, Ms. Lee.

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

Mr. JOLLY. Thank you, Mr. Chairman.

CLAIMS BACKLOG UPDATE

Mr. Secretary, a couple of quick questions. One, an update on the claims backlog. Last year we had an exchange, and you testified before the committee that it was 770 new FTEs. You felt confident you could eliminate the backlog. Can you give us an update on that?

Secretary McDONALD. Yes, sir. We have gone from about 611,000 at the peak in 2013. Now, we are down to 80 to 75,000.

Danny, do you have today's update?

Mr. PUMMILL. Yes. It is about 82,000.

Secretary McDONALD. About 82,000. The majority of those are difficult ones, ones where we are waiting for a piece of data. Can you characterize the ones that are left?

Mr. PUMMILL. Yes.

We will always have a certain number of claims in the backlog. There are certain claims that are just so complex, or because of trying to find records, mostly for older veterans, Vietnam-era veterans. It is gonna take longer than the average claims.

So we are gonna have some claims that are always going to be over 125 days. We estimate that number will be around the 60 to 80,000 mark.

Mr. JOLLY. For the Secretary, do you feel that we are on a pathway to eliminating the functional backlog, if we want to call it that?

APPEALS BACKLOG

Secretary McDONALD. I do. My big concern, right now, Congressman Jolly, is the appeals process. We have over 400,000. We have 440,000—

Appeals that we have got to solve. And the only way you are gonna solve that is with new legislation.

Mr. JOLLY. Right. And that is my next question. But I do want to zero in on this, because last year—because, look, the claims backlog is as significant as the VHA issue of 2 years ago.

And I have said this over and over. If Anderson Cooper decides to do a story on the claims backlog, we are gonna have the same outrage in the American public. And I appreciate what you are doing to try to solve it.

And the solution you presented last year was 770 new FTEs. We agreed to honor that request. I want to make sure that you believe we are on the pathway, because I know, this year, there is an additional request for more FTEs. I presume that is just because of growth of claims. Is that right?

Secretary McDONALD. That is correct. We have gone from, roughly, 950,000 to over 1.3 million a year.

Mr. JOLLY. OK.

Secretary McDONALD. So it is the growth of claims.

Mr. JOLLY. So but you still say the FTEs are the issue? Is that the solution?

Secretary McDONALD. They are——

Mr. JOLLY. Eight-hundred fifty——

Secretary McDONALD [continuing]. A partial solution. They are a partial solution. Obviously, taking the system to digital from paper has been a big deal.

SIMPLIFIED APPEALS PROCESS INITIATIVE

Mr. JOLLY. Right. Right. Right. And, so, then the overhaul of the appeals process. Can you kind of briefly describe what that overhaul would like that would help on that?

Secretary McDONALD. We have put a strawman piece of legislation in our budget proposal. We have 100 of those, 40 of which are new. One of them is the appeals process. But, as Danny said earlier, we are getting all the veterans service organizations, Congressional staff members, state directors of Veterans Affairs together.

We are gonna lock everybody in a room. We are gonna slip the food under the door and nobody is gonna come out until we have something written that everybody agrees with, or, at least, we identify those that disagree, that we can bring to you and it can pass immediately.

Mr. JOLLY. Well, thank you for doing that. And I understand that is coming up, right? That meeting is——

Secretary McDONALD. Next week. Right? Next week.

UPDATED NURSING HANDBOOK AND ANESTHESIOLOGISTS REQUIREMENTS

Mr. JOLLY. OK. And second, or third, question. You and I have also spoken in the past about the nursing handbook and whether or not there would be any changes in the nursing handbook that would conflict with the requirement to have anesthesiologists overseeing any of the work.

And the committee has been pretty clear, year after year after year after year on this issue, including last year, with report language suggesting that, you know, no changes should conflict with the current anesthesiologist handbook.

I know a proposed rule recently went to OMB. Can you maybe describe your position on this issue?

Secretary McDONALD. Yes. Our point of view, and David shares this point of view, is that, of all the things in the nursing handbook, the new nursing handbook with expanded, expanded duties, the thing we feel least comfortable about is anesthesiologists. So——

Dr. SHULKIN. Congressman, what I think we are talking about here is the CRNA component.

Mr. JOLLY. Right.

Dr. SHULKIN. And we believe that the teamwork-based model in anesthesia, right now, is effectively serving veterans. The most im-

portant thing that we are trying to address in the handbook is access to care.

Mr. JOLLY. Sure.

Dr. SHULKIN. We believe full practice authority for nurse practitioners will be very important for us, to expand primary care access. We are taking——

Mr. PRICE. But doesn't that conflict with what you just said, though?

Dr. SHULKIN. No. Primary care access.

Mr. JOLLY. OK.

Dr. SHULKIN. It is CNRAs, we feel that the current system is addressing access adequately.

Mr. JOLLY. So you support the existing anesthesiologist requirement in the handbook?

Dr. SHULKIN. Right now, and we spent some time with the chairman and ranking member on this yesterday, right now, in the VA, we believe that the current system is serving——

Mr. JOLLY. OK.

Dr. SHULKIN [continuing]. Veterans adequately and safely. We do think that, in the future, we may have to take a look at this, that if access does become a problem, that is a different issue.

Mr. JOLLY. Right.

Dr. SHULKIN. And, so, in the future we may have to look at this differently. But, right now, we believe it is serving veterans adequately.

Mr. JOLLY. And that is your viewpoint, as well, Mr. Secretary? All right. Thank you.

Mr. Chairman, Thank you.

Mr. DENT. Thank you, Mr. Jolly.

At this time, I would like to recognize the gentleman from North Carolina, for 5 minutes, Mr. Price.

Mr. PRICE. Thank you, Mr. Chairman.

MEDICAL AND PROSTHETIC RESEARCH BUDGET REQUEST

Welcome, Mr. Secretary, and your colleagues. We are happy to have you here. We appreciate your work. And I would like to turn to another area that is of great importance. It is an area in your budget, that I think would not be replicated anywhere else in the federal budget, were it not done by the VA, and that has to do with the particular focus you have on a certain kind of research, medical and prosthetic research.

You are asking for a modest increase in your research budget, totaling \$663 million. You make the point in your presentation that this is not the whole story, and I would like to—that may be elaborated somewhere. It was not elaborated in the material I saw.

You said that this was supplemented by \$1.3 billion, actually, from VA medical care, for a total of over \$2 billion in the research budget. So it is not completely clear to me what that refers to, and when you describe your research program, what comes from which budget line.

Now, when you talk about what the increase you requested will support, you are talking mainly, as I understand it, about two genetic medicine initiatives. One, what you call the Precision Medi-

cine Initiative, drawing on the million veteran database. And then, secondly, additional analysis of DNA specimens from that source.

So, two questions. Can you clarify what kind of money we are actually looking at, here, and where it comes from? What, then, secondly, what stock you place in the increases you want and the ventures that it will let you make into genetic medicine?

And then, I guess, finally, if more funding were available what would be the next line of research initiatives that you would aspire to?

Secretary McDONALD. Congressman Price, you raise an incredibly important point. The VA has been the source of innovation for American medicine, whether it is taking an aspirin a day to avoid a heart attack, the first implantable pacemaker, the first liver transplant, the first kidney transplant, working on heart disease.

And I haven't even mentioned injuries from warfare, but these are things that have happened at the VA. Three Nobel prizes, seven Lasker awards. VA research is essential. You asked about prosthetics. Last week, we did the first two operations in the United States, something called osseointegration in Salt Lake City, where we actually put a titanium rod in the veteran's bone, and then attached the prosthetic device to it.

One of those two veterans, last week, when they walked for the first time said, "I can now feel the grout cracks between the tile." And the reason for that is the nerves grow around that titanium rod and give it the sense that you would have if you had your leg.

And so, this incredibly important research. Last week, we also announced, with the President, our work on the Million Vet project, this genetic engineering. The fact that we have, right now, 450,000 blood samples.

We are going to have a million, one of which is mine. And we have 40 years of medical records that back those up, which is a gold mine for researchers to figure out how genetic changes effect disease.

And we had, on the panel with us, a veteran who had suffered uterine cancer, but because of us understanding her genome, we also know she is susceptible to colon cancer. So we have increased the rate of her colonoscopies to save her life.

Dr. SHULKIN. Congressmen, 90% of VA researchers have academic appointments with our—with the leading medical centers in the country. The VA research, as you know, is dedicated exclusively to helping veterans. It is actually, I think, the best investment that the American taxpayers have.

So, the \$663 million is provided by the U.S. government. The \$1.3 billion that you are talking about is actually extra mural funding. It is competitive funding that these researchers have gotten to support research. So, together, it adds up to that large number, the \$1.8, \$1.9 billion.

Mr. PRICE. The extra mural funding coming from NIH, NSF and also non-governmental sources, is that right?

Dr. SHULKIN. And non-governmental sources, all three, yes.

Mr. PRICE. So this isn't exactly leveraged funding, but it is funding that, for practical purposes, is combined with—

Dr. SHULKIN. Exactly.

Mr. PRICE [continuing]. Your base.

Dr. SHULKIN. Exactly, much like an academic center would count its research funding, yes.

Secretary McDONALD. Of course, Duke University is one of our best medical school affiliates, where a lot of research occurs.

Mr. PRICE. You said it, Mr. Secretary. You said it for me. Thank you. [Laughter.]

Thank you, Mr. Chairman.

Mr. DENT. Thank you. At this time, I would like to recognize the gentleman from Ohio for 5 minutes, Mr. Joyce.

Mr. JOYCE. Thank you, Mr. Chairman.

Secretary McDonald, from one of your prior answers, I have got to ask. Do you receive a bonus?

Secretary McDONALD. No, sir.

TYING BONUSES TO PERFORMANCE

Mr. JOYCE. Well, why is it acceptable for anybody else to receive a bonus, in your organization, if you are paying them a fair wage? Wasn't that part of the problem that we have had with people scamming the systems to achieve their bonus, before you took over, sir?

Secretary McDONALD. Congressman Joyce, given my experience at the Proctor & Gamble company, I would tell you that for similar work, that bonus becomes an essential part of fair compensation for government employees. Government employees, typically, are not well paid.

Our medical center directors are paid half what they would earn in a private sector. So that bonus becomes, in a sense, part of their compensation, and they look at it that way. What we have done, as I said earlier, is tying bonuses to performance.

We have actually reduced the spending on bonuses in the department, and we, also, have a distribution of rankings which matches the performance of the department. So I think we have got that under control, but I would hesitate to take away the bonus, unless you increase the compensation.

Mr. JOYCE. Well, maybe that is what we should do, pay a wage that is consistent with the industry, so get the best and brightest to be there at the veteran's administration, so they are taking care of the veterans. Wouldn't that—

Secretary McDONALD. Bonuses are another way to differentiate. At the Proctor & Gamble company, after about 6 years with the company, you would be eligible for a bonus program. So, what is done in government isn't out of question with the private sector. It is not totally inconsistent.

Mr. JOYCE. I get that, in the private sector. But in this sector, again, it was one of the causes for why people were scamming the system, if you will, to receive the bonus, pay the wage, and hold people accountable to the wage that they are being paid. And if they are not doing it, then they should be fired.

Now, the OIG was in here the other day, and they said they will take cases where they find people stealing money, and they take it to the Federal Government, and if the DOJ doesn't do anything with it with them. I said, well, why don't we take them to state prosecutors?

Secretary McDONALD. We have separated more than 2,600 employees, and that doesn't include over 500 who have chosen to resign or retire ahead of that. So accountability is incredibly important. We can't change the culture without holding people accountable.

Mr. JOYCE. And don't get me wrong, sir. I think you are a good and decent man. I think that you needed to be evaluated when you took this job, because the things you were doing in the private sector, I certainly appreciate your service in coming here and providing—

Secretary McDONALD. Congressman Joyce, as you know, I am not doing this for the money.

PRIVATE CONTRACTORS FOR APPEALS BACKLOG

Mr. JOYCE. I certainly got that, sir, and that is why I had to deal with that. Speaking of solutions, following up on the gentlemen from Florida, you talked about the backlog. You know, other agencies have used private contractors to help process that backlog to get current.

I see you put in money for full time equivalents, but, again, once you process the backlog, do you really need those people? And, so, I was wondering when and if your agency was contemplating that, and when and if in fact they were going to use it.

Secretary McDONALD. That is actually an interesting idea for our team that is getting together next week, because so much of the appeal is written into law. It is a law that is about 80 years old. It doesn't allow for private contractors.

Mr. JOYCE. OK, there is one of the solutions we could provide for you. Following up, another thing that you touched on before was mental health issues. You talked about an external partnership that you have, and I believe that was the Boston area, you mentioned with the Red Sox?

Secretary McDONALD. Just one example, we have many, including our medical school affiliates.

VETERANS CRISIS LINE RISK ASSESSMENT

Mr. JOYCE. You know, the access to mental health care is important. I don't think somebody who calls you and says they have an issue should have to wait 30 days to find somebody.

Have you thought about how we are going to do that, because these men and women have put their life on the line? They are obviously coming home and having some issues. How can we make sure that, when they make that call, they are receiving the treatment that they need?

Secretary McDONALD. One of the things that we have done, and we have worked very hard on this, is to modernize all our crisis lines, as well as to make mental health care available 24/7 at all of our medical centers. This is critically, critically important. We can't wait.

And, as you know, because we have reported this publicly, we brought in some new leaders of our crisis lines, people with experience. We brought in a lady who had run Philadelphia's 311. So we are applying private sector principles, methodologies. We are also

updating the equipment, and, David, why don't you talk about the hospitals.

Dr. SHULKIN. Yes, thank you for mentioning this. This is one of our key issues. As you know, our best data today, but we hope to update this in the next month, is 22 suicides a day among veterans. Seventeen of—

Mr. JOYCE. Twenty-two too many.

Dr. SHULKIN. Twenty-two too many, absolutely. Seventeen of them do not receive care in the VA system. So we are actually working now and reaching out to community groups to try to get those people engaged in the VA system.

When they call the VA system, we are committing to a same-day evaluation, or risk assessment, to make sure that anybody who needs care will get into the hospital, or see a psychiatrist, or speak to a mental health professional right away.

Mr. JOYCE. Thank you, and I realize I am out of time, Mr. Chairman. Thank you, very much, for your time, your answers.

Mr. DENT. Thank you.

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

Mr. FARR. Thank you, very much, Mr. Chairman. I would like to publicly invite you out to the opening of the first DOD VA designed clinic at the former Fort Ord on October 14.

Secretary McDONALD. October 14, I have got it on my calendar.

Mr. FARR. And when Mr. Dent gets an airplane, you can travel with us, so. [Laughter.]

But, I would like—

Secretary McDONALD. I fly coach.

PAYMENT OF VA HOSPITAL ADMINISTRATORS

Mr. FARR. I would like to follow up on Mr. Joyce's issues. I mean, one thing on these bonuses, we have Lisa Freeman, who runs the veterans' hospital at Palo Alto. When they were doing salary surveys in Silicon Valley, they chose her.

It is because in most cases the hospital administrators get the best salaries in local government. They told her if she left that job, she would immediately have a pay increase of a million dollars.

And this is for the comment is, you guys just don't pay your incredibly hot, great staff what they deserve. And I think the only way you can keep people like Lisa Freeman is to get a bonus. So I don't think we are going to change the whole salary structure. So I think it is a great issue, we just, you know, we want to retain talent. And—

Secretary McDONALD. Actually, we have—I am sorry to interrupt you, but just want to let you know. We have suggested that we take people like Lisa, who are currently senior executive service, to title 38, which would give us a lot more flexibility to pay her competitively.

Mr. FARR. Do you need to have legislative approval—

Secretary McDONALD. Yes, sir, we do. And we have given the prototype bill to both our house and senate authorizing committees, and we would appreciate your support.

Mr. FARR. Thank you. You have it. I mean, we have Palo Alto, which is an incredible center, and, you know, I am hundreds of

miles away. And, so, we are in a rural part of the area, and this clinic is really going to be interesting.

But what we are finding is, when we can't get psychiatrists to take the salary offered and to move into that area, we have created, in California, because of leadership of a judge in Santa Clara and the Silicon Valley, Judge Jim Manley, who created these veterans' courts, and he is sort of the guru of it.

He tells me that he won't refer. What he does is he gets, you know, all these problematic people. And what he says, "I just bend the law." He says, "But I am working with all the social services, ACLU and everybody. And I don't put people in jail," that is what he tells me.

His philosophy is, "I don't put people in jail." And he says, "Even with some serious crimes, I don't put them in jail, because jail is not going to cure their problem. But I do get them in treatment programs."

He says, "The problem with the veterans is that the wait is too long. It is an archaic system of treatment." He says, "Whereas, the counties have really come into sort of handling this stuff, sort of on the civilian side."

He says, "Well, I sentence my people to the county system." He said, "Even with the great Palo Alto Veterans Hospital, it is the system."

And I wondered whether, you know, you need any authorities to sort of modernize that system, because the last thing you can do, like intervention, is people say, "OK, I am ready, I am going to take this and I am going to go try to get treatment, or I am drug"—you can't say, well, then you have got to wait 30 days to a year for placement. It has got to be immediate.

VETERAN TREATMENT COURTS

Secretary McDONALD. No, you are absolutely right. Veterans treatment courts are perhaps the biggest innovation positive for veterans over the last 5 years. We have gone from virtually zero to now, I think, we are over 300, maybe a little bit less than 300.

And in every case, veteran treatment court keeps veterans out of jail and puts them into care. And going to jail, incarceration, is a one-way ticket to homelessness.

Mr. FARR. Yes.

Secretary McDONALD. So it is a great investment to eliminate homelessness to do these veteran treatment courts. Your judges experience is the first I have ever heard where, in some area of the country, we are not providing the case workers. We are providing the care in the right way and I—

Mr. FARR. His point is that the backlog in the veterans' system, is too long.

Secretary McDONALD. We are the largest employer of social workers in the country. So, I mean, I am going to dig into this with you.

Mr. FARR. Well, the point I am trying to make is, I think Mr. Joyce brought it up, is that these veterans who are going to local hospitals and going to sort of in the civilian world of medicine treatment and mental health treatment, we ought to allow that to happen—

Secretary McDONALD. Well, for sure.

EMERGENCY ROOM CARE REIMBURSEMENT

Mr. FARR [continuing]. Where there is a backlog, where there is an immediate and sort of the emergency. Because what is happening, and this is the second part of that, is when our veterans do end up in an emergency room, they are being charged by the hospital on their own personal account. And the reimbursement takes so long that they end up with credit defaults, which then go on their record.

And it just screws them up from then on because, you know, VA didn't get—

Secretary McDONALD. We agree with you. And one of the things we are also pursuing is in our Consolidation of Care bill, that takes these seven different ways of getting care in the community, all with different reimbursement rates, all with different criteria, combining those into one.

One of the things we have got to look at is the reimbursement of emergency room care. Right now, this is a big, big problem for veterans, because they have to be pre-cleared, in a sense, to go to a private emergency rooms.

So, that is part of that bill, and I think that is something we need to deal with.

MARRIAGE AND FAMILY CERTIFICATES AND ACCREDITATION

Mr. FARR. So shortening the wait lists and all of that, the other one I have talked to you about in my office is that you have a strange system of authorizing people for hire for marriage and family certificates trained by states. They have to go through a certain accreditation process.

And I understand that is not just true with marriage and family therapists. It is also true in a broader sense. Are you looking at the ability for VA to broaden your ability to hire behavioral health providers and others outside of that, just one-size-fits-all accreditation?

Secretary McDONALD. Yes, we are.

Mr. FARR. I mean, the University of California, Berkeley, Stanford, getting licenses in California and come work for you.

Secretary McDONALD. Good schools. Right. Good schools. We are looking at that. David.

Dr. SHULKIN. You are absolutely right. We do have a shortage of mental health professionals, and we do want to have people join the VA.

We are looking at the criteria and the curriculum of the California schools. The secretary has asked me to personally look into this. I will get back to you.

Mr. FARR. You may look for other profession providers, as you have that strict accreditation requirement.

Secretary McDONALD. Yes.

Mr. DENT. Thank you.

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

Mr. ROONEY. Thank you, Mr. Chairman. Thank you, Mr. Chairman.

APPEALS BACKLOG

Mr. Secretary, I just want to feed off of something that Congressman Jolly was talking about. You had said that you reduced the claims backlog from 675 thousand to around 82,000. But, now, that there is approximately 400,000 appeals pending.

I was recently speaking to Florida VFW officials, as well as Florida American Legion personnel. And one of the things that they expressed to me was that one of the problems is that the VA has moved personnel from the claims division or from the appeals division to the claims to reduce the backlog in claims. But, then, that has increased the appeals backlog.

So instead of trying to solve the problem, we have shifted that. And I said, "Well, why is that so?" And it is because we have too many managers, or supervisors, or people in pseudo-leadership positions in the VA, as opposed to actual just worker bees to knock out these claims. Now, is that true, in your opinion?

Secretary McDONALD. In my opinion, that is a red herring. I will ask Danny to talk more about moving people, but let me put some facts on the table. Ten to 11 percent of veterans appeal. So that is a relatively small number, but because we have gone from 950,000 claims a year to 1.6 million claims a year, the absolute number gets bigger. Of those 10 to 11 percent, 2 percentage points, so 2 percent, create 45 percent of the appeals.

So you have 2 percent of the veterans creating 45 percent of the work on appeals, and many of these appeals, as I said in my opening statement, have gone on for 25 years, 27 years, 29 years. It is just it is unfortunate that 2 percent—and the majority of those 2 percent are already getting a disability payment and are already rated totally disabled.

So, you know, we have an issue. We have got to deal with it, and that is why we are getting together next week. But, Danny, have you moved people?

OVER SUPPLY OF SUPERVISORS

Mr. ROONEY. Just, if I could just on that. Do you feel like one of the things that we have talked about with you over the course of your tenure has been sort of hierarchy on your staff?

Do you feel like the things that the VFW officials were telling me are accurate or inaccurate, as far as you being able to sort of put the chain of command that you think works most efficiently for that organization, as opposed to, you know, getting stuck with the way that it has been and not being able to move the wheel?

Secretary McDONALD. Yes. Ten of my top 16—10 of my 16 direct reports are new, since I have been confirmed. Everybody at this table, but me, wasn't here last year to testify. Ron was on staff, but at a different level.

Danny is the new leader of VBA. He has already made changes. I think you changed the chief of staff, if I am not mistaken?

Mr. PUMMILL. I have a new deputy.

Secretary McDONALD. New deputy, I mean. Yes. But could you talk about moving the people?

Mr. PUMMILL. Yes. We have a new deputy, new chief of field operations. And we are looking at the entire staff in the headquarters

to move people around to positions where they are better suited right now.

Mr. ROONEY. Well, I am not talking about moving around. I am talking about if you have got a bunch of people that are supervisors or managers, and then, you know, they are all sort of telling each other that they don't have to do the work, because they are in charge.

And then you have got, like, two people there that are actually knocking out claims or figuring out what the appeals are.

I got the sense from talking to these officials in Florida that the VA is still top heavy, rather than using the money and the resources that we appropriate to have personnel there that are better suited to just knock these claims out.

Mr. PUMMILL. No. We have the right people doing claims. As a matter of fact, we are probably just the opposite. We put everybody on claims last year, from the highest person in the RO, the RO director, down to people that were sweeping floors, if they could help with claims. Everybody was doing claims.

Your question about did I move people off appeals, yes, we did, last year. We moved some of the people off of appeals and put them on claims. But, even with that, I did 30 percent more appeals last year than we ever did before in our history. We did more appeals.

Those people are all back now, because we have our automation system in place.

Mr. ROONEY. OK.

Mr. PUMMILL. And it is working, so they are back on appeals. And last week, I directed \$10 million only for overtime for people in appeals to get them on the appeals process.

MENTAL HEALTH TRIAGE ASSESSMENT

Mr. ROONEY. OK. I have to cut you off, because I have 10 seconds. If I could just ask another question before the Chairman gavels me down. I am very sensitive towards my time. We, also, talked about PTSD and TBI.

We have some of the people that have come to see me and some of my constituents say one of the problems with the VA is that we are treating potential suicidal veterans with social workers—not that there is anything wrong with social workers. I have worked with plenty of them in a previous life.

But when you deal with somebody that is potentially suicidal and whether they are given a prescription from a therapist or being told to see a social worker versus going to see psychotherapist or a psychologist, how do you kind of put who you diagnose with somebody who is potentially suicidal with the person that is most likely gonna give them the help that they need?

Dr. SHULKIN. Very briefly. Excellent question. The field of mental health, actually, is a team-based approach. So there is a triage assessment, a risk assessment. And the higher level, the higher severity patients are assigned to psychiatrists.

And then there are psychologists and social workers that are part of the team, as well. So higher risks, a suicidal patient, should be under the care of the most advanced level practitioner, the physician.

FIRST TIME ORIGINAL CLAIMS

Mr. DENT. Thank you, Mr. Rooney. I would like to quickly follow up on something that Mr. Jolly and Mr. Rooney, both, were pointing out. They were discussing the VA claims backlog. And I was looking at these MyVA charts, this page, here, where we see in the bottom right corner that the number was 75,480.

For your claims backlog, I think Secretary Bob McDonald, you started to address that. But for that claims backlog, what percent are first-time claims? And you are correct when you say that some are already receiving some kind of a payment. It is not like they are not getting any money, in all cases.

But and how many are, maybe, second, third, or fourth or even more. As you noted in your testimony, you have a 25-year-old claim in the queue. So how many are first, second, third, fourth, et cetera?

Mr. PUMMILL. Those claims, those are original claims. They are about half. They are about 50/50. About half of those are veterans that have already filed a claim, and they are filing a new claim.

The appeals are a different bucket, entirely. They are not counted in this at all. Those are veterans that have filed a claim. The majority of them are already receiving compensation, also, generally, about 50 percent compensation. But they have an appeal. They have appealed a portion of their claim.

Secretary McDONALD. I don't know if that was clear or not. But on the chart you have—

Mr. DENT. About half, I guess—

Secretary McDONALD. Yes, that chart was only claims. That was not appeals. The appeals chart would be different.

Mr. DENT. OK. Thank you. That is a good clarification. I recognize Mr. Fortenberry. It is your time.

Mr. FORTENBERRY. No. Thank you for your deference, Mr. Chairman.

Good morning, everyone. Good morning, Mr. Secretary. Nice to see you all. I appreciate it.

NEBRASKA CENTER FOR EXCELLENCE PUBLIC/PRIVATE PARTNERSHIP

Mr. Secretary, as you are very much aware, Nebraska is prepositioned to help you build out a new VA center of excellence, a 21st Century model for care for our veterans with innovation, with continuity of care for existing problems, but, also, enhancement for specialization.

We are ready to enter into an innovative, unique, public/private partnership that I think has significant implications for the future of the VA and the innovation that needs to take place with current medical facilities, tight budgets and community good will.

Can we do it?

Secretary McDONALD. We sure want to. I think public/private partnerships is the way of the future for us. And we need to, you know, to prove out this model. And I think Omaha is a good place to do it.

As you know, I think we have finalized the scope and the cost estimates for the project. We are talking about 157,000 square feet,

including primary, specialty care, radiology, ambulatory surgery. We estimate the cost will be \$136 million.

We have got \$55, \$56 million appropriated. But we are working hard to figure out what legislation do we need and how do we need to get this scored to get this done. And, to me, those are the two things on the critical path. And we are working with you to do it.

Mr. FORTENBERRY. In the old days, we would put money aside and put it under the mattress until we had enough to build out something. It is not working anymore. We all know this. Now, there are public/private partnerships that already exist in housing and other areas of the government.

We got a report from you. I received it just yesterday. We are having some trouble deciphering what exactly it means. But whatever authorization you need, whether it is in appropriations or through regular authorizing processes, we stand ready to assist you.

There really is no reason not to do this, because we are getting hung up on some of the nuances of accounting. The opportunity cost of not doing this is huge. So when will we have specifics on what you need to be able to empower you to move forward on this? I think that is the next stage answer that we need.

Secretary McDONALD. Yes, I think we should have that done in a week-and-a-half to 2 weeks.

Mr. FORTENBERRY. Oh, great. Excellent. Well, that would be very, very helpful. As you are very much aware, right now, I think what the problem is is any community partnership, any private sector allocation that comes to you would be counted as a score, a cost to the VA. And this seems to be very peculiar.

Secretary McDONALD. If it is a leaseback situation, CBO and OMB tend to score it that way.

Mr. FORTENBERRY. OK. So we are not necessarily, in this case, looking at a leaseback. We are looking at, basically, the community partnership—

Secretary McDONALD. That is why I think this one should lead the pack, because we don't have that constraint.

Mr. FORTENBERRY. Yes. Well, again, right now, we have got about close to \$60 million set aside. This has taken years and years to get that number. The projected buildout with public funds is so huge, it would never occur.

So we stand ready to fully partner with you. And the potential resources are there in the Omaha community. I think, once a commitment is made, these numbers, perhaps, are a little bigger than the earlier estimates, but I would like to think that momentum would occur, because there is such a deep commitment in the community to assisting the VA to what will be a new model policy innovation that, I think, has implications for the rest of the country.

Secretary McDONALD. Absolutely agree.

Mr. FORTENBERRY. OK. I like the answers I am hearing, Mr. Chairman, so I will yield back my time.

Secretary McDONALD. I have work to do.

FY 2018 MEDICAL SERVICES ADVANCE BUDGET REQUEST

Mr. DENT. That is a first, today. Great. Thank you.

Mr. Secretary, we realize the uncertainty of making medical care estimates for fiscal year 2018 advanced budget request, not knowing if veterans will continue to increase their reliance on the VA for care, or where they will seek care, you know, VA or care in the community.

But your budget request for 2018 seems dubiously low. On a comparable basis, including Choice, your 2018 request is below 2017. It would require cutting 13,500 physicians and decreasing medical care by \$4.4 billion. I don't think we have ever had a year-to-year decrease. I don't think that has ever happened at the VA.

That portends an enormous second bite at the apple, if you will, in the request for next year's budget. It is not going to be much of a welcome gift for your successor. Why didn't the administration send us a more realistic advance budget request for 2018?

Secretary McDONALD. Mr. Chairman, I think there are a number of things. Number one is, we are trying to figure out this hybrid network that we are going to have between private sector and public sector. We are in the throes of doing that.

Number two, as you know, the Choice Act funding goes away at the end of 2017. We have got to figure out how we transition from that to a sustainable system, long term. Number three, consolidation of care in the community. We have put in a proposal forward to our authorizers.

There is a lot of uncertainty on that proposal, and we don't know, depending upon what our authorizers choose, whether or not they deal with the emergency room issue, whether or not they deal with the increased demand issue. We don't know what the cost will be.

So I agree that there probably will be some more cost, particularly for care in the community in 2018. But any number we came up with would be a guess, at this point. We will have to work with you on it, as we get more certainty.

HEPATITIS C DRUG TREATMENT

Mr. DENT. OK. Well, thank you. We look forward to, you know, continuing that conversation. Let's shift to hepatitis C. As you are very much aware, the committee was very supportive of the need for additional funding for hep C treatment for veterans and provided \$1.5 billion in the 2016 conference report.

Your 2017 second bite at the apple requests \$840 million, in order to maintain the program level, that program level of \$1.5 billion in 2017. We understand that the price the VA pays for hepatitis C drugs has dropped. I think I discussed that with Dr. Shulkin and some of your other staff.

It has dropped from \$40,000 down, on average, about \$20,000. How many cases per week will you now be treating using the \$1.5 billion? And if the \$1.5 billion level were sustained in the out years, how long would it take to treat the entire eligible VA population? Dr. Shulkin?

Dr. SHULKIN. Yes. Mr. Chairman, we believe that we have about 120,000 veterans with hepatitis C. Our original estimates, when we submitted this, were that we were gonna be able to treat about 35,000 veterans a year. That would take us about 5 years. Now that there has been an adjustment, we believe that we can treat many more veterans.

We have about doubled that, so at about 70,000 veterans a year, which, if you do the math, would be about 1,300 veteran starts a week of new therapy. We should be able to eliminate the backlog in about 2, 2½ years.

Mr. DENT. OK.

Dr. SHULKIN. And, as you know, about 95 percent, as you told me yesterday, this is a curable disease. This is one of the best advances that we have had in recent times. So this is great news for veterans.

Mr. DENT. It is great news and it is, I guess, a little bit more complex now, given the opioid issue and what we are learning about the connection between hep C and heroin abuse.

Dr. SHULKIN. Yes.

SIMPLIFIED APPEALS PROCESS INITIATIVE

Mr. DENT. And I don't know how that is affecting the veteran population, but I suspect it is affecting veterans, as it is the civilian population. On the issue of disability claims, it is good the department is tackling the next looming backlog in appeals of initial disability claims.

But, I have to say that I am a little bit skeptical that the authorizing committees will be willing to tackle the legislative provisions that are necessary to make your plan work, especially in the election year.

BOARD OF VETERANS' APPEALS BUDGET REQUEST

It also seems unlikely Congress will be able to provide enough funding to increase your staffing from the current 680 to the required 5,100 to erase the backlog without legislative changes.

What about the option of technology? The claims backlog has been helped immensely by the implementation of the Veterans Benefits Management System, which has made the claims process paperless.

Is there something similar that could be developed for appeals? I am not sure, Secretary, who should take that one.

Secretary McDONALD. I can answer part of that, Mr. Chairman. Part of it, we are already in the process of doing. And that is doing hearings by videoconference, rather than personal appearance. And we have been able to convince our veteran service organizations that the conclusions of those are as positive as they would be with a personal appearance.

So that has made us much more efficient with the limited number of judges that we have. I don't know how much farther we can go, though, using technology, given the way things are written into the law.

Dr. SHULKIN. We are getting ready to push the appeals into the VBMS system. That is gonna help us a little bit. Short of some kind of change in the law, though, and how we do appeals, we don't see us ending the appeals backlog.

Even if we threw people at it, we couldn't afford to throw enough people at it to solve the problem with the way the appeals legislation is written right now.

Mr. DENT. Thank you.

My time has expired. I am going to recognize the ranking member of the subcommittee, Mr. Bishop.

SIMPLIFIED APPEALS PROCESS INITIATIVE

Mr. BISHOP. Thank you, Mr. Chairman. Mr. Secretary, I want to return to my reference earlier, to the board of veterans appeals. Your budget proposes to simplify the appeals process through legislation and provide additional resources toward that effort.

Regarding the authorization, it is very unclear, at this point, if the authorizers are going to take up the proposal. So my first question is what benefit would be the increase to the VA appropriation, if the accompanying authorizing legislation is not passed?

Then, correct me if I am wrong, but it appears that this proposal would limit a veteran from updating his file, as it goes through the process. Will the veterans still be able to submit additional information, or is there a cutoff point under your new proposal?

Secretary McDONALD. Ranking Member Bishop, it depends how the group comes back with their ideas next week. The strawman that we have put into our budget proposals, the 100 proposals we have, is one that would freeze the Form 9, which means the individual would submit a new Form 9, with a new claim.

Again, that is going to be looked at next week, and we will have a better idea. I think, you know, we have raised this—I am sorry, sir.

Mr. BISHOP. Have you consulted with the VSOs to get a buy in from them, before you release the proposal?

Secretary McDONALD. Yes. We are working with them right now. And we are also working with the state directors of Veterans Affairs, as well. And they will be part of the workgroup next week.

But back to the legislation, I mean, I hear you and Chairman Dent, both saying that you think the probability of us getting this legislation from the authorizers is low. I mean, I think that would be irresponsible, right?

I mean, this issue, this appeals issue, has been with us a long time. All of us know that. And, dog-gone it, we need to have the courage to do something about it. You know, the idea that 2 percent of veterans are providing 45 percent of all appeals, and some of them going 25, 27, 28, years, is simply not right.

We are punishing the 99 percent of veterans who are appealing and doing the right thing. And, so, we have got to get after this. And we are going to continue to work with Chairman Miller and Chairman Isaacson to make sure we get this legislation.

Mr. BISHOP. Mr. Secretary, I understand that. But, given where we are in this calendar year, given the challenges that Congress will face this year, and also given the fact that the VSOs are very likely not to be inclined to support preventing veterans from continuing to supplement that record during their appeals, simply because, through no fault of their own, in many cases, their records are not complete, because of having been lost, papers having been lost or disconnected within the VA process.

Secretary McDONALD. Well, I don't know. I don't know about that, but, you know, one of the things I learned in the military is we all look out for each other. And this idea that 2 percent of peo-

ple can effect a bad outcome for 98 percent of people just does not make sense in a military culture.

So we are going to work with the veteran service organizations. We are going to come up with an optimal solution. And we will bring that to authorizers, and we will expect them to pass it or get it through committee.

Mr. BISHOP. That is all I have, Mr. Chairman.

Mr. DENT. I would like to recognize the gentleman, Mr. Jolly, for 5 minutes.

Mr. JOLLY. Thank you, Mr. Chairman.

MEDICAL APPOINTMENT SCHEDULING SYSTEM (MASS)

Mr. Secretary, or for the panel, when we talked about the VistA replacement that is likely coming, I know prior to your administration, 2015, there was a little over 600 million allocated for MASS.

With this, now, the plan, are abandoning MASS? Initially, it was supposed to be a national rollout. Then, I understand, it was brought back to a pilot program in certain communities.

But can you give us an update on MASS, the funding for MASS, and how it plays with this?

Secretary McDONALD. Sure. Congressman, as you know, we have selected the MASS project, and we are now in the process of evaluating a pilot site for that. We have selected Boise, Idaho, as a potential pilot site.

We have, actually, put the implementation of the pilot site on hold for a brief time, in order to make sure that we are making the best decision for veterans and the best decision for taxpayers.

We are rolling out the VistA scheduling enhancement right now. As I mentioned, to three sites. The one site is active in Asheville, North Carolina. We will roll that out further, nationally, in April, at the same time, evaluate how that is serving our scheduling needs, using the MASS option, in case the VistA scheduling is not meeting all of our needs, so that we can go forward with that implementation.

So far, I think that we have spent about \$9 million on the MASS project implementation. And we have other money allocated to support the pilot, should we decide to go forward with that, later on this year.

Mr. JOLLY. So, generally speaking, though, MASS has greater capabilities, greater function, far more comprehensive than this enhancement.

Secretary McDONALD. That is correct.

Mr. JOLLY. So can you maybe walk us through the decision to go with VSE and delay, or put on hold, MASS?

Dr. SHULKIN. Yes. You are correct. The MASS project has, or the MASS product, has much greater capabilities. It is actually a process engineering tool, where we would re-engineer the way that we actually deliver clinical care.

So it is much more than just a scheduling tool and has other advances, that we are looking at right now. Our schedulers, as the Secretary said, using that green screen—

Mr. JOLLY. Sure.

Dr. SHULKIN [continuing]. Are in such desperate need of trying to meet the veterans' needs today, improving access, that we feel

the responsible thing for veterans right now is to get them tools that are available.

And that is why we have rolled out this to them in January. We do not want to hold that up, while we are looking at what the right decision is for the system. If it turns out that VistA scheduling enhancement, once our schedulers get what you see up there, is really meeting the majority of the needs of veterans and of schedulers, probably the right decision for taxpayers is not to spend up to \$663 million that you saw that this contract, you know, has the cap at, but to be able to continue to roll out VistA scheduling evolution.

So this pilot that we are doing right now with VistA scheduling evolution in April is gonna be very, very important for us to understand whether that is meeting the needs of our schedulers and veterans.

Mr. JOLLY. What is the additional functionality of MASS? In other words, what is the delta that is being left off the table, if you will, by going VSE?

Dr. SHULKIN. Yes. It is primarily a process engineering tool that will help us design our workflow in our clinics. That is the primary advantage. VSE is really only a GUI interface in our VistA scheduling system.

We, also, are rolling out something called VAR., which is a mobile application for veterans to actually request and get appointments on their mobile phones. That is, also, being rolled out, as well.

Mr. JOLLY. OK.

Dr. SHULKIN. And, LaVerne, anything else about MASS, the capabilities?

Mr. JOLLY. And I would ask, for a layperson who is not familiar with IT, can you explain kind of in plain language what that delta is? What are we leaving off the table by not pursuing MASS?

Dr. SHULKIN. What this is the whole process of how you schedule appointments is more than just the computer interface.

Mr. JOLLY. Right.

Dr. SHULKIN. VistA scheduling evolution is, really, that computer interface. So a scheduler can see what appointments are available, how do I quickly get a veteran into an empty appointment. That is what you are seeing on what looks more like a Microsoft screen.

Mr. JOLLY. Sure. Right.

Dr. SHULKIN. That is what we are doing right now. What we are evaluating is, is it worth it to invest hundreds of millions of dollars into something that is much deeper, that actually connects the way that we schedule appointments behind the scenes in a much more sophisticated way.

That is why we went through the MASS selection process—

Mr. JOLLY. OK.

Dr. SHULKIN [continuing]. And that is the decision which we are gonna be making very soon, whether we test this in Boise, to start.

Mr. JOLLY. OK. And I didn't mean to cut you off, if you had anything to add to that.

Ms. COUNCIL. No, I think the one thing to remember, and this is the learning around VistA, is we have 130 different instances. And a key part of really being able to make change fast is that we have got to think through that architecture and get ourselves to a

much more simplified state, so that MASS or any new capability will be easier, versus harder.

Mr. JOLLY. OK. Thank you.

Mr. Chairman, thank you.

Mr. DENT. Thank you, Mr. Jolly.

At this time, I would like to recognize the gentleman from North Carolina, Mr. Price.

Mr. PRICE. Thank you, Mr. Chairman.

VETERANS TREATMENT COURTS

Mr. Secretary, in looking at relatively new and non-incremental items in your budget, I do want to ask you to focus on this caregiver support that you are concentrating on. But I first want to pick up on the exchange you had with Mr. Farr and the reference to the veterans' courts.

And just this, not necessarily a budgetary item, but want to ask you to elaborate a little bit on your experience with this. My experience, at home, is just remarkably favorable. One of our relatively small counties, Harnett County, has pioneered with the veterans' courts. Two-year anniversary just observed.

It is a small scale. Six graduated last year. Seventeen veterans currently participating. Fourteen waiting to be accepted. Somewhat hampered by the difficulty of getting qualified mentors, but that is coming along, too.

I know this is a source of referrals to you. It is a source of some pretty difficult care cases, no doubt. But I am sure it is the kind of problem you welcome. And, so, have you found formal or informal ways of encouraging this development and scaling it up?

Secretary McDONALD. Yes, sir. In fact, when I came into this job, as a business guy, I looked at what are the rates of return of all the studies we have done on homelessness. And one of the primary deliverers of the highest rate of return is a veterans treatment courts.

Eliminating veterans' homelessness has the highest rate of return of any investment I have ever seen, because if you don't eliminate that homelessness situation and provide the veteran the care, they end up in emergency rooms and all other bad things happen, that become much more expensive.

So we have been going around the country identifying where do we need veterans' treatment courts. Where do they not exist? And one of our current pieces of work is in Los Angeles County, which happens to be the place where we have the most homeless veterans.

And we have veterans treatment courts in the counties around Los Angeles, but not in Los Angeles county. And, so, I have been working there. We have eliminated a lawsuit that was existing there. We put out a new master plan for our 390-acre campus there.

But one of the important things we have got to do is get our veterans treatment court in Los Angeles County. And, so, we are working on that. If we do that, that will help us eliminate veterans homelessness. Very high rate of return.

Mr. PRICE. Thank you. The estimate, judges at home tell me, is every dollar invested, saving \$20. That—

Secretary McDONALD. That may be low, but I——

Mr. PRICE [continuing]. That may be low?

Secretary McDONALD [continuing]. That is a good place to start.

Mr. PRICE. But so much of this, up until now, has depended on the initiative of local judges, people who understand the value of this, to the extent there can be national leadership and encouraging this and facilitating it.

Secretary McDONALD. You are exactly right. We have systematized it. So we, actually, go across the country, and we look for pockets where they don't exist. And we work with the judicial system there.

There is also, now, an Association of Veteran Treatment Court Judges that get together once a year. I always come and speak to them, and we talk about new advances. We, also, talk about what are the geographies where we don't have them, where we need them.

CAREGIVERS

Mr. PRICE. Good. Well, let me, now, segue to caregiver support. This is an item you have given some focus to, I know. Anybody who is looked in on veterans' care in their communities is going to appreciate this, as just a pressing and growing need. How are you dealing with it in this budget?

Secretary McDONALD. I am going to ask David to comment in a minute, but from my standpoint, caregivers is one of the most important initiatives that I am trying to drive. When we send a service member to war, the family goes with them.

And we have got to do a better job of caring for these caregivers. At the same time, we have a national crisis in caregivers. As the American population ages, their going to be seeing the same problems with caregivers that we, in the VA, already see when people come back from the battlefield.

So we have been working very closely with the Elizabeth Dole Foundation. And we have been working very closely to make sure that our programs for caregivers are robust. So, for example, I was recently in California, and I attended a session we were doing with people, older veterans, who were suffering some form of dementia.

We were doing music therapy with them. While we were doing that therapy, we had all of their caregivers in a different room, and we were helping them solve their problems. And they were helping each other solve their problems.

So this becomes very, very important. And, as you know, the law is that if you are a caregiver post 9/11, you get support. If you are a caregiver pre-9/11, you do not. So this is a great inequality that somehow I suggest the Congress needs to deal with. David?

Dr. SHULKIN. Yes. I think, Congressman, as you see, we have requested additional money this year in the current budget request for additional support for caregivers, because, exactly as the Secretary said, we have found this is so valuable.

This is an important return on investment. If you didn't have caregivers supporting these veterans, they would be requiring additional inpatient care and additional services. And, so, we hear how valuable this is.

And this is one of the big differentiators of the VA health care system from the private sector, where getting caregiver support is very, very difficult.

Mr. PRICE. Thank you.

Thank you, Mr. Chairman.

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

Mr. JOYCE. Thank you, Chairman Dent.

HUD-VASH COMBATING VETERAN HOMELESSNESS

Secretary McDonald, you were talking about the homelessness situation before. And I have noticed that you ask for \$1.6 billion for combating veteran homelessness. In particular, \$496 million for the Housing and Urban Development Veterans Affairs Supportive Housing program, known as HUD-VASH.

As a member of that committee, as well, can you tell us and the other members of this committee, just how your agencies are coordinating to tackle this issue?

Secretary McDONALD. That is a great question, a great question, Congressman Joyce. We have an interagency council that works together against homelessness, and, as you know, the President, who's put priority focus on veterans' homelessness.

The work that Secretary Castro, Julián Castro, Secretary Perez, Labor, and I do together is so critically important that we decided to actually travel together to demonstrate to the local communities how important it was to work interagency to get this done.

Obviously, Labor is about getting the veterans employed. Secretary Castro's about getting them housed. And then, importantly, we provide the care. It is not really just about the housing, it is also about the care.

So we travel together. The HUD-VASH program is, frankly, a miracle, because it allows us to give a voucher to a veteran. It allows them to go under roof. It follows a strategy called housing first.

Housing first doesn't mean housing only, but it means if you get that low level of Maslow's Hierarchy of Needs solved, you can then provide the care. And the individual will work with you on the care, because the housing's already taken care of.

One of the things we have had to do is work in different communities, No. 1, to increase the HUD-VASH voucher amount. We have increased the amount twice in Los Angeles. Number 2, work with landlords to rent. And we have done mayors' challenges, and I have done challenges to get the mayors to rent to HUD-VASH voucher holders.

Number three is to get developers to build new housing, because, in some communities, there just isn't the housing stock. And we can bundle the vouchers to do that. So it is a really, really positive program.

Mr. JOYCE. That is great to hear.

Secretary McDONALD. Last year, we took care of 365,000 veterans and their family members.

Mr. JOYCE. It is great to hear. And it is great to hear that it is coordinating the funds, to make sure that we are delivering the services that are necessary.

IT ENTERPRISE SECURITY STRATEGY

Ms. Council, I appreciate the fact that you have taken over a rather large task. I know when I was going to visit VA hospitals, one thing they talked about was the inability to coordinate platforms. So that, certainly, has to be an issue for you.

And the fact that you are taking this, and I noticed that you have asked for \$370.1 million, which is a 105 percent increase over the 2016 enacted level, in order to—will you, please, tell us what you are doing with this increase in funding to help protect the veterans' very sensitive information?

Ms. COUNCIL. I think you are referring to our new security budget.

Mr. JOYCE. Yes.

Ms. COUNCIL. And fully supporting security. One of the key initiatives, when I first came into this role in July, was to secure and think about our security much more holistically across the enterprise.

So, within the first 90 days, we created our enterprise security strategy. It includes eight core domains within the organization, and, frankly, changes our posture as to how we secure information, who is using it.

We included privacy into it, as well as governance, education, and, also, how we hire. So the use of those dollars are, really, to fully fund our elimination of our material weakness, by going after some more FISMA and FISCAM issues and repeat issues that we have had.

Our objective is, by the end of 2017, we would have eliminated all of those material issues. And, so, that is, really, our focus. We are going into each of those sites. We are working with our auditors to get out in front of when they are coming in, but, also, to make sure that we are truly remediating these issues and eliminating them for good.

Mr. JOYCE. And preparing for any type of cyber-attack, as well?

Ms. COUNCIL. We are always preparing for any kind of cyber-attack. And the real issue with security is that you are always on defense, but you, also, have a great deal of offense that you can do. And we are ensuring that we are, also, doing that, through education.

Mr. JOYCE. And one last question, if you will. Who do you believe those records—who do you believe those are? You are, the VA's—

Ms. COUNCIL. Those are the veterans' records. And we do have the responsibilities, as the stewards, to protect them.

Mr. JOYCE. Thank you, very much.

Back to you, Mr. Chairman.

Mr. DENT. Thank you. With 4 seconds remaining.

OK. This time I would like to recognize the gentleman from California, Mr. Farr, for 5 minutes.

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

I want to congratulate you on your distinguished career. West Point graduate, private sector CEO, and, now, Secretary. You know, I have sat on this committee almost 20 years, and this is the only committee, in either House of the Congress, that has both DOD and VA responsibility.

I have always thought that, if this was a perfect world, VA could work themselves out of a job, because people would get out of the military, as they get out of all kinds of things. And, then, they just go back into the civilian world, and we take care of them.

We have created this silo that is now a \$178 billion silo that is—it is very good, what we are doing, but it is, also, very expensive. And, I think, that is why Mr. Fortenberry and I are sort of Siamese twins on this collaborative idea that we ought to try to go back.

And I know you, really, understand that and want to bring in more market mechanisms to stimulate services to be better. I have got a problem, because we have sort of the perfect solution.

TRANSITIONAL HOUSING

When Fort Ord closed, the largest training base in the United States to ever close, a lot of that housing we acquired through local veterans' organizations as transitional housing. Our community college built a campus there. We have the new VA/DOD clinic going in. We have a new cemetery going in, veterans' cemetery.

And this housing is for homeless veterans. And they have housed families. They have had to raise the money to rehab these housing, because the Army never built it for California code standards.

It is expensive. But, once you get those families into that housing, they are there for 3 years. And they can walk to every service they need. The thing they all need is, you know, the treatment. They have got serious problems. That is why they are homeless.

Our HUD vouchers, which are wonderful, but guess what? The rents in this area are so high that nobody will take them. And, yet, what we need to do is rehab some more of these houses. They have got the facilities.

Can you help us do that? And not just use all the money to get vets into housing, because, in some places, that is not going to work. And transitional housing that you can stay in for 3 years, is a long time.

And, so, this is, probably, the safest, best kind of—we call it the veterans' village, where you can be located. And we don't have anything to stimulate creation of more of those, or to help those that have actually created them.

So the question is, can you make sure that, where there are resources for homeless veterans, that we support those?

Secretary McDONALD. Yes. I couldn't agree with you more. When I was in Los Angeles, we did a thing called the Blue Butterfly Project, where we used some old Navy housing. And we put female veterans in and their children.

But one of the things we are working on in VA is to become a more principle-based organization, rather than a rule-based organization. I know that sounds unusual to members of Congress, who create rules. But sometimes the rules get in the way of taking care of the veteran.

And, in this particular case, there was a law that said, well, you can't have housing for female veterans only. You know, but what female veteran and her family, single female veteran, wants to live in a neighborhood of male veterans? But, you know, we found a way around it, because we worked on the principle of taking care of those veterans.

So, again, the HUD-VASH voucher amount, in Los Angeles, we have raised it twice. I think we need to take a look at the HUD-VASH voucher amount in your district and see if it is meeting the needs of veterans. And, if not—

Mr. JOYCE. It is the same as that of all of California coastal cities—

Secretary McDONALD. Yes, absolutely.

Mr. JOYCE [continuing.] Are just the most expensive places to rent in the United States.

Secretary McDONALD. I need to—

Mr. JOYCE. But this is different. We have got the housing.

Secretary McDONALD. I understand.

Mr. JOYCE. We just need to fix it up. And what comes with this housing is treatment, which, you know—

Secretary McDONALD. Yes.

Mr. JOYCE [continuing]. Is a little bit more difficult with—

Secretary McDONALD. In the Blue Butterfly Project, we used private-sector partners. Home Depot Foundation, others that helped us fix up the housing. So we know how to do this. So we will get together on it and make sure we take advantage of that housing.

DOD AND VA COSTS OF WAR

Mr. JOYCE. One last comment, if I can. My time is just about out. You have 10 months left. You bring a unique vision to this, and with your military background. I think that we are dealing with so many problems that DOD ought to be handling. Sort of they dump their problems on VA.

You can't get into VA unless you have been through DOD. So if sort of the cause of problems are while you are in the DOD community, why can't we hold DOD more responsible? These are, essentially, the costs of war. And I think you have the unique ability to suggest some of these things that ought to be carried by DOD and their budget, and not fall on your responsibility.

Secretary McDONALD. We have a very good relationship with Secretary Carter. And we have had many very open and honest discussions. To me, it really goes back to we, as a society, have to understand the cost of war, after the veteran comes home, before we send them into the war. Because, you know, that is where the greater costs exist, at least in human terms.

Mr. JOYCE. Could the DOD do some ounce of prevention?

Secretary McDONALD. Well, I think that is part of it. But I, also, think it is all of us who may call for the use of military force need to make sure we understand what it is like when you come out. You know, David was referring to this earlier, for the first time in our history, I think, we have five veterans who are quadriplegics, who have no arms and no legs.

Yet, if you met these individuals—I am thinking now of Sergeant Travis Mills from the 82nd Airborne division, he could walk right in front of you, and you would have no idea. But people are 10 times more likely to survive the battlefield, but they are gonna survive with more grievous injuries.

And we have to recognize that, and we have to prepare for it before we send people into harm's way, rather than wait till they come out and then wonder why the budget's going up.

Mr. DENT. Thank you, Mr. Farr.

I have one last question, I think, and the ranking member has one last question. Then we will conclude the hearing. But I, also, have a few questions that I will submit for the record that you can respond to, then, at your convenience.

CONSOLIDATION OF CARE

Secretary, we know that you are sending the Hill your legislative proposal to consolidate all the non-VA care programs into one program, as you were directed by statute.

How will the new program, if enacted, be managed within the VA? And how long will it, realistically, take to get it up and running? And how do you propose to strengthen the business and claims payment processes in the new consolidated program, which have been weak to-date and caused low participation?

Secretary McDONALD. That is a great question. We have set up a whole new office to manage this, with a whole new leader. David, why don't you go through the details of that, if you don't mind?

Dr. SHULKIN. Yes. Within VHA, I have established a new deputy under secretary for community care and an organization that is, really, developing the infrastructure to manage this. We are very anxious to move on with this. That is why we are looking for the support in the legislative authorities to move forward with the plan that we submitted in October of 2015.

We believe that we will be able to go out with a RFP, in the fall, to be able to start making decisions on what we were gonna do in-house and what we can get from the private sector. We do believe that outsourcing, for some of these functions, is a realistic option, if we can get the right bids back in.

And, so, we have very aggressive plans to be able to implement this. We are gonna be doing this on the fly, as the train's moving, because we are taking care of veterans in the community every day.

Mr. DENT. Thank you, Dr. Shulkin. I have nothing else.

Representative Bishop.

Mr. BISHOP. Thank you, very much.

PATIENT TO NURSE RATIO

One last question. I recently met with an individual from the VA hospital, located in Dublin, Georgia. And he raised a concern that there is, currently, a 10:1 patient and nurse ratio in the VA health care system, as compared to 7:1 ratio in the private sector.

And, while I understand that the VA ratio is high, in comparison to the private sector, I, also, recognize that the VA operates under very different fiscal constraints. Are there any efforts underway right now to bring in more registered nurses, in order to bring down that ratio within the VA health agency?

Dr. SHULKIN. OK. I would be glad to answer that. As you know, I have spent my entire career running hospitals in the private sector. The ratios are not fixed, except for in states that legislate that, like California.

In general, a ratio of between 7 to 10 is what you will find in many hospitals across the country. It depends on the severity of

the patient. Most hospitals have a severity adjusted nursing/staffing ratio.

The VA health care system is, absolutely, within the standards of private sector, certainly, not worse than that. Do we have a nursing shortage in some areas, like in Dublin, Georgia, where it is hard to recruit nurses? Absolutely. We have open solicitations for nurses to join the VA. We are eager to have all qualified candidates.

But I do not want to give the impression that the nursing care in VA is anything less than you would find in the private sector. In fact, just recently, in the "Journal of the American Medical Association," a month ago, independent studies found that VA outcomes, mortality rates, are actually better than the private sector, in conditions like acute myocardial infarction and congestive heart failure.

DUBLIN, GEORGIA VA MEDICAL FACILITY

Mr. BISHOP. Yes. I guess, in connection with the VA center at Dublin, this individual was concerned that being able to keep up with veterans, especially those that have brain injury, PTSD, or other mental health concerns require a lot more close supervision.

And, with that high ratio, it works a real hardship on the staff. And sometimes it places them at great risk, both the patient and the staff. And he raised that question with a genuine, authentic concern. And I told him that I would bring that to your attention and find out what, if anything, could be done about that and if anything was being planned for that.

And, obviously, there are some fiscal restraints.

Secretary McDONALD. Yes. You know, I have been to the Dublin facility. I spoke to the director, Mary Alice, earlier this week. We are very focused on nursing. Every hospital knows that it is only as good as its nurses. It is the single most important professional to have the right staff in the right numbers.

And you are, absolutely, right. The spinal cord injury patients and TBI patients require intensity of services of nursing that really are almost incomparable to other services.

So we are focused on that. Dublin, as you know, is a challenge, because of its location. But we are doing everything we can to get the right professionals there.

Mr. BISHOP. Thank you.

Mr. DENT. Thank you, Mr. Bishop.

I just want to inform the members that our next hearing, of course, is tomorrow, tomorrow morning at 9:30 a.m. for the secretaries of military installations, in room 210 on the House side of the Capitol Visitors Center.

So this hearing is adjourned.

[Questions for the Record submitted by Congressman Dent for the Honorable Robert A. McDonald follows:]

Question: VA has been working for years to amend a regulation to recognize a new accrediting agency for clinical psychology. This change is necessary because current VA regulations require that to be hired by VA a psychologist must graduate from an American Psychological Association (APA)-accredited program. But there are now two fully recognized accrediting bodies – the APA and the Psychological Clinical Science Accreditation System (PCSAS). After two years of review, in May, 2014, the Undersecretary for Health approved the change. But now, 21 months later, the VA still has not formally adopted the change, even though all internal VA approvals have been granted. Delays seem counterproductive when VA badly needs more behavioral health specialists. When will the regulation be amended? I'd like to know a firm timeframe.

VA Response: On March 22, 2016, the Assistant Secretary for Human Resources and Administration signed the revision to the psychologist qualification standard and sent it to the Office of Information and Technology for certification and publication. It is expected to be published the week of May 23, 2016.

Question: Provide a chart showing all non-VA care obligations, actual or projected, including the Choice program and Medical Community Care, from FY2012-2017.

VHA Response: Please see chart.

Question: Identify actual or estimated funding for VA employee travel, conferences, and performance bonuses for FY 2015-2017.

Answer VA:

**VA Travel Spending
(Dollars in Millions)**

Purpose	FY 2015 Amount	FY 2016 thru Feb Amount
Training	\$52.3	\$16.7
Conference*	\$24.4	\$7.1
Information Mtg.	\$12.6	\$4.5
Site Visit	\$25.1	\$7.6
Other	\$7.6	\$2.5
Special Mission	\$8.7	\$2.8
Patient Care	\$5.8	\$2.5
Speech/Presentation	\$2.1	\$0.6
Invitational	\$1.0	\$0.3

Emergency	\$0.1	\$0.0
Entitlement	\$0.0	\$0.0
Relocation	\$0.0	\$0.0
Detail	\$4.8	\$1.8
TOTAL	\$144.5	\$46.4

* The conference amounts noted in this table differ from those in the *VA Conference Spending* table that follows because it represents conference travel costs only, whereas the *VA Conference Spending* table includes all conference costs (i.e., travel, supplies, contracts, etc.).

Travel Estimates in the 2017 Budget **
(\$ in millions)

Account	FY 2016	FY 2017
VHA	\$74.2	\$74.5
VBA	\$35.5	\$39.6
NCA	\$3.0	\$3.1
OIT	\$9.4	\$10.3
BVA	\$0.5	\$0.6
Gen Ad	21.4	\$21.7
TOTAL	\$144.0	\$149.8

** FY 2017 data is not identified in the budget by purpose categories. Table reflects travel by discretionary account, VA's Office of Inspector General is excluded.

VA Conference Spending*
(Dollars in Millions)

FY	Number of Conferences	Costs Reported to Congress
FY 2015	540	\$58.1
FY 2016 Q1**	129	\$4.6
FY 2016 Q2 ***	175	\$20.0
FY 2017	# of Conferences not identified in the President's Budget	Conferences spending not identified in the President's Budget

Notes:

* Data Source: Conference Oversight and Reporting Knowledgebase. Expenses include travel, supplies, and other costs to support VA-sponsored conferences. Data does not include VA participation in non-VA-sponsored conferences.

**FY 2016 Q1 conference spending is based on a Congressional report dated January 25, 2016.

***FY 2016 Q2 data are projections from VA's January 25, 2016, Congressional report. Once final conference data are known, actuals will be provided.

Performance Awards

The table below reflects all types of awards across VA from FY 2011 to 2015. Across the board, total VA spending for awards has declined even as VA full-time equivalent employment increased from nearly 296,000 in FY 2011 to over 335,000 in FY 2015, an increase of approximately 13 percent. Between FY 2011 and FY 2015, spending for all categories of awards dropped by \$150 million (37 percent). Between FY 2011 and FY 2015, spending for Senior Executive Service (SES) bonuses dropped by approximately 65 percent, from \$3.7 million to \$1.3 million. These reductions are largely due to strengthening controls and rigorously linking awards to performance.

	2011	2012	2013	2014	2015
Performance Award	\$ 183.7	\$ 139.1	\$ 153.8	\$ 172.2	\$ 169.3
Relocation, Retention, Recruitment	\$ 144.0	\$ 115.0	\$ 81.0	\$ 65.9	\$ 60.5
Special Contribution	\$ 77.0	\$ 49.7	\$ 47.8	\$ 36.8	\$ 27.4
SES Bonus Awards	\$ 3.7	\$ 2.3	\$ 2.7	\$ 2.8	\$ 1.3
	\$ 408.4	\$ 306.1	\$ 285.3	\$ 277.7	\$ 258.5

Award targets are based on Office of Management and Budget/Office of Personnel Management guidance, which for FY 2017 will be released early in the next fiscal year. For FY 2016, individual performance awards are estimated to be similar to the totals in FY 2015.

As reflected in the chart above, SES awards have been reduced by approximately 65 percent since FY 2011. A recent Executive Order by the President has increased the SES awards limitation to 7.5 percent of the aggregate salaries of all VA executives. This increase would provide a total VA SES annual awards pool of about \$4.2 million. However, because awards are closely linked to performance, the actual amount paid out may be less. VA SES awards will be issued based on performance and in compliance with law, Executive Order, and Office of Management and Budget/Office of Personnel Management guidance.

Question: As the veteran population ages, VA bills for long term care are rapidly growing. In fact, your "second bite at the apple" request includes an additional \$712 million for long term care above the base of \$7.9 billion. VA provides long term care in multiple ways – VA nursing homes, private community nursing homes, State nursing homes, and home-based care. Some of these settings are more expensive than others and eligibility requirements are different. As you try to cope with this growing responsibility, do you have a long term strategy for defining the type of long term care VA will provide and the veterans who will be eligible for it?

VHA Response: VA is pursuing efforts to provide Long-Term Services and Supports (LTSS) in a way that honors Veterans' preferences by increasing the availability of home and community-based services that can reduce the need for admissions to facilities, such as VA Community Living Centers, Community Nursing Homes, and State Veterans Homes. By moving toward a more balanced offering of home and community-based services, which are less costly than facility-based options, VA anticipates that projected growth in expenditures for LTSS can be moderated.

However, more than 50 percent of enrolled Veterans who use VA for health care are over the age of 65, and it is projected that the number of Veterans with greater than 70 percent service-connected disabilities will double in the next decade. If these 70 percent service-connected Veterans need nursing home care, VA is required by current law to provide it. VA is also required to furnish nursing home care to any service-connected Veteran in need of such care for their service-connected disability.

Concurrently, anticipated demographic changes will lead to fewer potential informal caregivers and an increase in the number of eligible female Veterans who are more likely to be widowed, divorced, or never married. These changes in the Veteran population, and the U.S. population in general, will increase the need for LTSS in all settings.

VA is developing strategic plans that take into account these projected demographic changes and the care options that will be available to optimize the health, independence, and well-being of all Veterans facing the challenges of aging, disability, or serious illness, so that we can provide the highest quality care possible at the best value for the most Veterans. VA is also developing guidance on assessing the need for these services based on functional status to improve the consistency of decisions regarding the provision of these services.

The strategic plans focus on honoring Veterans' preferences for staying at home as long as possible by shifting the balance of LTSS to a growing proportion of community-based options. Yet, if a Veteran needs facility-based LTSS, VA's goal is to maintain its ability to provide care, while also ensuring that the care is provided in environments that are as home-like as possible. A legislative clarification proposed by VA is important to ensure that VA has access to home and community-based services. Legislative clarifications are needed to clarify VA's authority for purchasing non-VA care, including purchased care. We therefore urge enactment of legislation based on VA's proposed "Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act," which was transmitted to the Congress on May 1, 2015.

Current rebalancing of resources to provide more services and supports in Veterans' homes has delayed or helped Veterans avoid facility-based care. VHA is also actively developing and implementing pilot demonstrations for models of care to allow Veterans to remain in their own homes.

Question: As you are aware, the Committee continues to focus not only on new construction, but also the effective operation and maintenance of the existing building stock that constitutes the bulk of VA's building portfolio. In order to effectively operate buildings, protect taxpayer investment and deliver quality services, building personnel not only need access to education and training, but must also demonstrate competency through attainment of professional credentials recognized by the facility management industry. This was the premise of the Federal Buildings Personnel Training Act (FBPTA) enacted by Congress in 2010 with strong bi-partisan support.

Question: An October 2015 GAO report (Federal Real Property: Additional Authorities and Accountability Would Enhance the Implementation of the Federal Buildings Personnel Training Act of 2010) found that VA has not provided clear guidance to building personnel on training and certification requirements that are prescribed under the FBPTA.

Question: What is causing the delay in training and certification?

VA Response: VA owns over 6,200 buildings, of which over one-third are deemed historic in nature. Approximately 90 percent of VA's buildings belong to VHA and are health care or support facilities - these average 55 years in age, well beyond the average infrastructure age for non-Federal and Department of Defense health care facilities. Documented infrastructure deficiencies for severely degraded conditions, as evaluated by Facility Condition Assessments, will cost an estimated \$17 billion in repairs/replacements.

Professional and trades employees generally maintain VA's facilities. By utilizing our own employees, the Department can respond to unplanned natural and manmade events in not only the delivery of mission-essential services, but also by providing critical infrastructure support to the Department of Defense and local communities.

VA has identified the following requirements for development of an education, training, and certification program for facility operations and management:

- Fully account for the number of VA employees, lessors' employees, and contracted workers;
- Determine the training needs of individual VA employees, according to level of responsibility, supervision, and the type and size of the facility and campus (e.g., research, radiological hazards, flood zone);
- Provision of specific and individual certifications based on function (occupation and expertise);
- Identify number of dedicated FTE necessary to run the program; and
- Obtain financial resources to support the planning, development, implementation, management, and updates.

There are between 24,000 and 30,000 VA employees who operate and maintain buildings or component systems. These employees include but are not limited to those who impact energy consumption and operating costs; oversee work performed by building or equipment service contractors; or protect the health, safety, and productivity of its occupants. Additional employees who may be subject to the Federal Buildings Personnel Training Act (FBPTA) include those who work in non-standard facility-associated occupations, (e.g., dialysis centers with oversight of water treatment systems specific for use in dialyzing procedures; VA police officers who manage building access and security systems; providers of home-based primary care who manage oxygen systems, drug treatment and rehabilitation residences, mobile medical and mental health centers, and other unique Veterans' health-based environments).

As of June 2016, VA has executed over 2,000 leases, 1,600 of which are clinical leases, to provide space for outpatient clinics, Veterans Centers and other Veterans' resources. The number of non-VA (contract) staff working in each leased site will not only vary from one facility to the other, but also can vary during the lease period. Current lease contracts, while compliant with Federal Acquisition Regulations and VA Acquisition Regulations, with few exceptions (e.g., instances specific to life support systems such as maintenance of medical air systems) do not require the specific reporting or evaluation of qualifications of the lessors or lessor's contracted workforce.

The number of VA contract staff who may be subject to the Act can potentially exceed 100,000. Most facility-specific support and construction contracts are managed at the local facility level. Similar to leases, VHA facility contracts for services, maintenance, and construction, with few exceptions, do not require specific reporting or evaluation of the contractor's workforce.

Question: How does the VA plan to address these delays?

VHA Response: VHA is reviewing options to strengthen national oversight and to enhance technical and program support for the operation and maintenance of medical facilities. Planned realignments of staffing, along with associated budgeted resources (educational, financial, etc.) to the VHA Office of Capital Asset Management Engineering and Support will enhance national oversight capabilities and provide needed resources to increase technical engineering program support and establish a Service Support Division with a focus on workforce development. This existing resource realignment is projected to be budget-neutral and completed by the end of fiscal year 2016.

The first action for the Workforce Development Team will be to identify employees who have primary (e.g., engineers, etc.) and auxiliary (e.g., biomedical staff, clinicians, police, etc.) duties or functions in the areas of energy, facility operations, maintenance, and safety. The total number of employees subject to the FBPTA, is estimated to range between 24,000 and 30,000 nationwide.

Concurrently, the Workforce Development Team will oversee the identification and development of function-specific competencies for employees who address the complexities and needs of health care facilities in the areas of energy, facility operations, maintenance, and safety. (*Note: Current GSA-developed competencies related to FBPTA focus on commercial/business occupancy-type facilities—not health care or research laboratories.*). Upon completion, function- and duty-specific competencies will be added to employee position descriptions.

Upon completion of the first two actions, VA will conduct a gap analysis to identify and prioritize employee training needs. For the remainder of FY 2016, VA will reallocate budgeted training resources, and, in future years, resource needs specific to compliance with the FBPTA will be included in VA budget requests.

Question: What, if any, resources or authorities are required in order to expedite this critical first step in delivering well maintained facilities?

VA Response: Full implementation and long-term sustainment of the FBPTA requirements is not cost neutral to VA. As stated above, the inherent complexity and estimated number of impacted employees and contractors will require a significant budget adjustment to enable the dedication of additional resources specific to FBPTA implementation, sustainment, and education.

In addition, the average age of VA-owned facilities exceeds 55 years, and documented infrastructure deficiencies are estimated at \$17 billion in repair/replacement costs for infrastructure needs evaluated with grades of *D* or *F* in Facility Condition Assessments. If significant productivity and efficiency gains are to be made, existing outdated and unserviceable building systems and major components must be updated and/or replaced. This requires appropriation of significant additional funding.

The Office of Personnel Management can assist VA in fully implementing the FBPTA by incorporating specific competency requirements into impacted position classification standards; issuing guidance for the hiring and retention of talented, experienced personnel to meet statutory requirements; and evaluating identified classification and pay gaps compared to private sector job markets.

Question: In your efforts to create a more veteran-focused workforce within the VA, what considerations have been given to expanding the number of veteran exclusive jobs within VA or to opening more positions up for Veterans Employment Opportunities Act – eligible veterans to apply to that are currently available exclusively to existing VA employees?

VA Response: VA currently employs over 119,000 Veterans (32.7 percent of our workforce); second only to the Department of Defense in total number of Veterans in the Federal government. The government-wide Veteran employment percentage is 30.8 percent.

When used properly, Veterans Preference can help enhance the VA workforce. VA's Veteran Employment Services Office proactively works with hiring managers and human resources (HR) offices across VA to educate them on the provisions of Veterans Preference and encourages the use of non-competitive appointing authorities to bring highly qualified Veterans and transitioning Servicemembers into VA's workforce.

Title 5 United States Code 3310 and 5 Code of Federal Regulations 330.401 restrict the competitive examination and the filling of positions of guards, elevator operators, messengers, and custodians to preference eligible Veterans as long as they are available.

Job announcements restricted to "VA employees only" are generally restricted in accordance with VA's Merit Promotion plan or bargaining unit

agreements. Notwithstanding those restrictions, qualified preference eligible Veterans (whether or not they are current VA employees) may still be considered for those positions under special hiring authorities for which they are eligible.

Description	2012 Actual	2013 Actual	2014 Actual	2015 Actual	2016 Estimate	2017 Estimate	2018 Estimate
Health Care Services:							
Ambulatory.....	\$1,544,316	\$1,705,426	\$1,752,061	\$3,320,039	\$3,317,655	\$3,782,178	\$2,097,257
Inpatient Care.....	\$1,323,128	\$1,539,479	\$1,742,151	\$2,480,735	\$2,329,672	\$2,655,862	\$1,472,703
Mental Health*				\$171,577	\$165,216	\$194,781	\$108,008
Dental Care.....	\$124,572	\$124,572	\$124,572	\$177,268	\$171,013	\$201,616	\$111,798
Health Care Services [Total].....	\$2,992,016	\$3,369,477	\$3,618,784	\$6,149,619	\$5,983,556	\$6,834,437	\$3,789,766
<i>*FMS doesn't allow for granularity relating to the is program</i>							
Long Term Services & Supports:							
Community Nursing Home.....	\$617,412	\$660,591	\$720,907	\$861,464	\$969,603	\$1,012,378	\$1,064,090
Community Non-Institutional Care							
Community Adult Day Health Care.....	\$52,963	\$57,028	\$65,965	\$119,692	\$123,711	\$132,625	\$135,496
Home Respite Care.....	\$22,712	\$26,595	\$30,934	\$35,399	\$37,457	\$40,062	\$43,102
Purchased Skilled Home Care.....	\$165,644	\$181,650	\$273,267	\$319,249	\$333,502	\$348,986	\$365,392
Hospice Care.....	\$67,341	\$70,619	\$76,903	\$90,817	\$93,464	\$96,329	\$99,223
Homemaker/Hm. Hlth. Aide Prgs.....	\$321,817	\$350,016	\$429,253	\$721,119	\$778,602	\$817,723	\$864,082
Subtotal.....	\$630,477	\$685,908	\$876,322	\$1,286,276	\$1,366,736	\$1,435,725	\$1,507,295
State Nursing Home.....	\$800,304	\$891,158	\$987,945	\$1,049,756	\$1,166,253	\$1,268,888	\$1,388,354
State Home Domiciliary.....	\$58,133	\$60,132	\$56,278	\$58,298	\$62,855	\$66,361	\$70,583
State Adult Day Care.....	\$553	\$504	\$2,807	\$1,031	\$892	\$1,029	\$1,195
Subtotal.....	\$2,106,879	\$2,298,293	\$2,644,259	\$3,256,825	\$3,566,339	\$3,784,381	\$4,031,517
Other VA Programs Care:							
CHAMPVA.....	\$929,305	\$1,027,544	\$1,141,793	\$1,061,597	\$1,212,266	\$1,530,368	\$1,671,700
Spina Bifida.....	\$25,256	\$28,391	\$30,801	\$32,352	\$53,002	\$58,026	\$57,601
FMP.....	\$26,364	\$23,769	\$27,685	\$27,051	\$64,644	\$31,280	\$34,151
CWV.....	\$0	\$0	\$0	\$0	\$200	\$200	\$200
Caregivers (CIC portion).....	\$5,841	\$11,548	\$13,995	\$17,398	\$21,483	\$28,059	\$24,981
Indian Health Services.....	\$0	\$6,245	\$14,999	\$14,999	\$15,000	\$28,062	\$29,358
Camp Lejeune - Veteran Purchased Care.....	\$0	\$0	\$4,662	\$6,377	\$13,619	\$11,347	\$11,794
Camp Lejeune Family.....	\$0	\$0	\$0	\$506	\$10,273	\$9,840	\$8,050
Subtotal.....	\$986,766	\$1,097,497	\$1,233,935	\$1,160,280	\$1,390,487	\$1,697,182	\$1,837,835
Total Obligations	\$6,085,661	\$6,765,267	\$7,496,978	\$10,566,724	\$10,940,382	\$12,316,000	\$9,659,118

Description	2012 A		2013 A		2014 A		2015 A		2016 E		2017 E		2018 E	
	Disc.		Disc.		Disc.		Disc.		Disc.		Disc.		Disc.	
Health Care Services:														
Ambulatory	\$1,544,316	\$1,705,426	\$1,752,661		\$2,252,120	\$1,067,919	\$1,320,039	\$2,496,285	\$821,370	\$3,317,655	\$1,115,015	\$2,667,163	\$3,782,178	\$2,097,494
Inpatient Care	\$1,323,128	\$1,539,479	\$1,742,151		\$1,477,000	\$1,003,735	\$2,480,735	\$1,998,000	\$331,672	\$2,329,672	\$782,836	\$1,873,026	\$1,472,619	\$0
Mental Health*					\$171,487	\$90	\$171,577	\$165,216		\$165,216	\$57,431	\$137,350	\$194,781	\$108,035
Dental Care	\$124,572	\$124,572	\$124,572		\$109,454	\$67,814	\$177,268	\$133,344	\$37,669	\$171,013	\$59,336	\$142,280	\$201,616	\$0
Health Care Services [Total]	\$2,992,016	\$3,369,477	\$3,618,784		\$4,010,661	\$2,139,558	\$6,149,619	\$4,792,845	\$1,190,711	\$5,983,556	\$2,014,618	\$4,819,819	\$6,834,437	\$3,789,766
Long Term Services & Supports:														
Community Nursing Home	\$617,412	\$660,591	\$720,907		\$648,130	\$213,334	\$861,464	\$852,002	\$117,601	\$969,603	\$1,012,378	\$0	\$1,012,378	\$0
Community Non-Institutional Care														
Community Adult Day Health Care	\$52,963	\$57,028	\$65,965		\$119,692	\$0	\$119,692	\$123,711	\$0	\$123,711	\$132,625	\$0	\$132,625	\$0
Home Respite Care	\$22,712	\$26,595	\$30,934		\$35,399	\$0	\$35,399	\$37,457	\$0	\$37,457	\$40,062	\$0	\$40,062	\$0
Purchased Skilled Home Care	\$165,644	\$181,650	\$273,267		\$319,249	\$0	\$319,249	\$333,502	\$0	\$333,502	\$348,986	\$0	\$348,986	\$0
Hospice Care	\$67,341	\$70,619	\$76,903		\$90,817	\$0	\$90,817	\$93,464	\$0	\$93,464	\$96,329	\$0	\$96,329	\$0
Homemaker/Hom. Hlth. Aide Prgs	\$321,817	\$350,016	\$429,253		\$322,312	\$398,807	\$721,119	\$555,650	\$222,952	\$778,602	\$817,723	\$0	\$817,723	\$0
Subtotal	\$630,477	\$685,908	\$876,322		\$887,469	\$398,807	\$1,286,276	\$1,143,784	\$222,952	\$1,366,736	\$1,435,725	\$0	\$1,435,725	\$0
State Nursing Home	\$800,304	\$891,158	\$987,945		\$1,049,756	\$0	\$1,049,756	\$1,166,253	\$0	\$1,166,253	\$1,268,888	\$0	\$1,268,888	\$0
State Home Domiciliary	\$58,133	\$60,132	\$56,278		\$58,298	\$0	\$58,298	\$62,855	\$0	\$62,855	\$66,361	\$0	\$66,361	\$0
State Adult Day Care	\$553	\$504	\$2,807		\$1,031	\$0	\$1,031	\$892	\$0	\$892	\$1,029	\$0	\$1,029	\$0
Subtotal	\$2,106,879	\$2,298,293	\$2,644,259		\$2,644,684	\$612,141	\$3,256,825	\$3,225,786	\$340,553	\$3,566,339	\$3,784,381	\$0	\$3,784,381	\$0
Other VA Programs Cares:														
CHAMPVA	\$929,305	\$1,027,544	\$1,141,793		\$1,061,597	\$0	\$1,061,597	\$1,212,266	\$0	\$1,212,266	\$1,530,368	\$0	\$1,530,368	\$0
Spina Bifida	\$25,256	\$28,391	\$30,801		\$32,352	\$0	\$32,352	\$53,002	\$0	\$53,002	\$58,026	\$0	\$58,026	\$0
FMP	\$26,364	\$33,769	\$27,685		\$27,051	\$0	\$27,051	\$64,644	\$0	\$64,644	\$31,280	\$0	\$31,280	\$0
CWVY	\$0	\$0	\$0		\$0	\$0	\$0	\$200	\$0	\$200	\$200	\$0	\$200	\$0
Caregivers (CIC portion)	\$5,841	\$11,548	\$13,995		\$17,398	\$0	\$17,398	\$21,483	\$0	\$21,483	\$28,059	\$0	\$28,059	\$0
Indian Health Services	\$0	\$6,245	\$14,999		\$14,999	\$0	\$14,999	\$15,000	\$0	\$15,000	\$28,062	\$0	\$28,062	\$0
Camp Lejeune - Veteran Purchased Care	\$0	\$0	\$4,662		\$6,377	\$0	\$6,377	\$13,619	\$0	\$13,619	\$11,347	\$0	\$11,347	\$0
Camp Lejeune Family	\$0	\$0	\$0		\$506	\$0	\$506	\$10,273	\$0	\$10,273	\$9,840	\$0	\$9,840	\$0
Subtotal	\$986,766	\$1,097,497	\$1,233,935		\$1,160,280	\$0	\$1,160,280	\$1,390,487	\$0	\$1,390,487	\$1,697,182	\$0	\$1,697,182	\$0
Total Obligations	\$6,085,661	\$6,765,267	\$7,496,978		\$7,815,025	\$2,751,699	\$10,566,724	\$9,409,118	\$1,531,264	\$10,940,382	\$7,496,181	\$4,819,819	\$12,316,000	\$9,659,118
Funding Sources:														
Discretionary:														
Medical Services (0160)	\$6,085,661	\$6,765,267	\$7,496,978		\$7,815,025	\$0	\$7,815,025	\$9,409,118	\$0	\$9,409,118	\$0	\$0	\$0	\$0
Medical Community Care (0140)	\$0	\$0	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$7,496,181	\$0	\$7,496,181	\$0
Subtotal	\$6,085,661	\$6,765,267	\$7,496,978		\$7,815,025	\$0	\$7,815,025	\$9,409,118	\$0	\$9,409,118	\$7,496,181	\$0	\$7,496,181	\$0
Mandatory:														
Veterans Choice Act (Public Law (113-146))	\$0	\$0	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$158,441	\$158,441	\$0
Section 802, Administration (0172XA)	\$0	\$0	\$0		\$0	\$412,872	\$412,872	\$0	\$1,531,264	\$1,531,264	\$0	\$4,661,378	\$4,661,378	\$0
Section 802 Medical Care (0172XB)	\$0	\$0	\$0		\$0	\$2,338,827	\$2,338,827	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Section 802 Emergency Care in the Community (0172XE)	\$0	\$0	\$0		\$0	\$2,751,699	\$2,751,699	\$0	\$1,531,264	\$1,531,264	\$0	\$4,819,819	\$4,819,819	\$0
Subtotal	\$6,085,661	\$6,765,267	\$7,496,978		\$7,815,025	\$2,751,699	\$10,566,724	\$9,409,118	\$1,531,264	\$10,940,382	\$7,496,181	\$4,819,819	\$12,316,000	\$9,659,118
Total Funding Sources	\$6,085,661	\$6,765,267	\$7,496,978		\$7,815,025	\$2,751,699	\$10,566,724	\$9,409,118	\$1,531,264	\$10,940,382	\$7,496,181	\$4,819,819	\$12,316,000	\$9,659,118

[Questions for the Record submitted by Congressman Rooney for the Honorable Robert A. McDonald follows:]

Mr. Secretary, in your testimony before the VA Committee, you were asked how you're addressing a shortage of health care providers within the VA system. You requested authority for an "80 hour workweek" and "Title 38 categorization for medical center directors" to address worker flexibility and pay issues.

Question: Can you get into a little more detail about these requests, and specifically address whether or not they would help incentivize doctors, nurses and health care providers to work in VA outpatient clinics, like the Sebring clinic in my district?

VHA Response: VA is confident that enactment of this legislation would have a positive impact on the Department's ability to recruit clinicians. While the primary intent of the legislation is to broaden scheduling flexibility for hospitalists and emergency medicine physicians, the "80-hour workweek" legislation as drafted would apply to all VHA physicians and physicians' assistants. Consequently, this should have a positive impact on VA's ability to recruit and retain physicians providing care in outpatient settings, particularly as VA works towards its goal of enhancing access, including expanded hours in the evenings and weekends. The legislation does not include language related to nurses and other health care providers as the current Title 38 requirements addressed apply to physicians. However, it is anticipated that there is potential for enactment of the legislation to also have a positive impact on recruitment and retention of nurses and other health care providers, particularly those that would be interested in employment opportunities/tours of duty that would be available due to expanded hours of clinical care (e.g., flexible scheduling/part-time positions).

The legislative proposal for the appointment of Medical Center Directors and Network Directors under Title 38 would establish an appointment and compensation system that will have a significant impact on the overall management of the Department's health care system. Each executive would be evaluated against appropriate market pay criteria including, but not limited to, complexity of the assignment, applicable labor market salary data, experience, accomplishments, and overall results-driven performance. Although not directly incentivizing health care providers at VA outpatient clinics, this proposal will strengthen facility leadership. Senior Executives at the Veterans Integrated Service Network (VISN) Network Director level have oversight for health care delivery at multiple VAMCs, numerous community-based outpatient clinics, nursing homes, and domiciliary centers. These Senior Executives are critical for the success of VHA's mission and ensuring quality health care. Under their leadership, VHA is a highly effective, innovative, data-driven, evidence-based, continuously improving, and reliable health care system. VAMC Directors and VISN Network Directors not only have oversight for enhancing the quality of medical care and the infrastructures, but also initiatives as stated in VHA's Strategic Plan, Fiscal Years 2013 – 2018. These include enhancing Veteran's access to health care; expanding telehealth and rural health services; improving access to mental health care; ending homelessness; and improving efficiency. These Senior Executives are charged with

maximizing revenue streams, determining prioritization of hiring, and identifying clinical and administrative efficiencies.

Question: What are the greatest challenges to increasing the number of staff at outpatient VA centers like the clinic in my district? How do you plan to both incentivize doctors to work at VA outpatient clinics, vet them properly, and do so in a way that's competitive with the private sector?

VHA Response: One of the most significant challenges for recruitment of staff, particularly physicians, at outpatient clinics relates to limited numbers of clinicians in a number of communities, particularly rural and highly rural areas.

As the Nation's largest integrated health care delivery system, the Veterans Health Administration's (VHA) workforce challenges mirror those of the health care industry as a whole. As physician shortages exist throughout the private sector, medical schools are growing to address these shortages. In order to carry out the primary patient care mission of VHA and to assist in providing an adequate supply of health personnel to the Nation, VA is authorized by Title 38 Section 7302 to provide clinical education and training programs for developing health professionals. VA conducts the largest education and training effort for health professionals in the U.S. VA has several training programs designed and tailored specifically to encourage medical professionals to work at rural VAs: the Rural Health Training Initiative. These training programs are unique in that they span a variety of professions including physicians, dentists, nurses, social workers, pharmacists, optometrists, and others.

VA employs an aggressive, multi-faceted strategy to recruit and hire physicians, primarily through the USAJobs.gov and VACareers.gov websites. Executive and clinical leaders at VA medical centers assess physician staffing needs. Physician shortages or deficits at specific locations are addressed by increased marketing and recruitment efforts on a case-by-case basis. The VHA National Recruitment Program provides an in-house team of skilled professional recruiters employing private sector best practices to the agency's most critical clinical and executive positions. The national recruiters, all of whom are Veterans, work directly with VISN Directors, Medical Center Directors, and clinical leadership in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs.

VHA markets directly to direct patient care providers for rural locations through its partnership with 3RNet (National Rural Recruitment & Retention Network), a national network of non-profit organizations devoted to health care recruitment and retention for underserved and rural locations. Through this partnership, VHA has access to a robust database of candidates especially interested in, and leveraged against, its rural vacancies. National Recruiters routinely post VHA practice opportunities on 3RNet's career page. In addition, 3RNet annually dedicates the month of November to Veteran health care awareness by making VHA its featured employer for the month.

VHA also strives to relocate physicians from urban areas to rural VAMCs. The increase in the rural Veteran population calls for a strong recruitment, marketing, and advertising campaign that directs qualified prospects to rural VA centers struggling to open their doors. The rural relocation marketing campaign targets urban physicians in transit during their daily commutes with a compelling recruitment marketing and advertising campaign to persuade them to explore options for relocation to the nearest rural VAMC. This extensive campaign targets geographic regions and specialties with highest need, online and in a wide range of professional health care publications.

To incentivize candidates, facilities may choose to designate their hard-to-fill rural positions for all or some of the VHA recruitment and retention incentives, including Education Debt Reduction Program, recruitment bonuses, relocation expenses, retention bonuses, and ongoing training funded by VHA. All clinical candidates for VA facilities, regardless of location, complete the VetPro credentialing and privileging process to vet them to provide care and ensure that their credentials and references are fully established. The VetPro Credentialing System is required of all VHA licensed, registered, and certified health care providers. The system is used nationwide in all VHA health care facilities.

In addition to actively recruiting primary care physicians, increasing and further incorporating nurse practitioners and physician assistants with specialized training and experience in primary care into care teams will increase Veterans' access to care.

Mr. Secretary, another complaint I hear often from veterans is that they don't receive *therapy* for the treatment of PTSD – they only receive prescriptions. This has to do with the lack of providers, but I'm also concerned that while there are so many treatments, including one on one and group therapies, touted by the VA, that I don't see them in practice in some parts of my district.

Question: Secretary McDonald: You mentioned in your testimony in the Veterans Affairs Committee hearing that you've seen success in alternative treatments, such as equine therapy, acupuncture and yoga. What are your metrics of success? Is that something that you are keeping track of and how? If these initiatives have been successful, what are you doing to ensure that the practices are being spread across the national VA system, specifically to outpatient clinics and to rural areas?

VHA Response: VA believes it is an unfair and inaccurate generalization to state that "don't receive therapy for the treatment of PTSD" from VA. The Department continues to dedicate significant resources across the breadth of VA programs, including research, for Veterans to have access to the best treatment available for PTSD. Each medical center within VA has PTSD specialists who provide treatment for Veterans with PTSD and there are nearly 200 specialized PTSD treatment programs throughout the country. Each PTSD program offers education, evaluation, and treatment. Program services include:

- One-to-one mental health assessment and testing
- One-to-one psychotherapy and family therapy
- Group therapy (covers topics such as anger and stress, combat support, partners, etc.) or groups for Veterans of specific conflicts or specific traumas

Currently, there are various complementary and integrative health (CIH) services offered within VHA, but not to the degree in which they are needed. There is limited evidence to recommend CIH services as a specific treatment for PTSD. However, some CIH practices may be useful adjuncts to existing evidence-based therapies. Given the current state of the evidence, the decision to use a CIH therapy is a decision best made between the Veteran and the treating provider to ensure the CIH modality is incorporated as part of a comprehensive approach to the management and treatment of PTSD. Further research is needed to determine what role CIH practices such as yoga, acupuncture, and meditation, which have shown promise in small trials and anecdotal reports, should have in the treatment of PTSD.

The VHA Office of Patient Centered Care & Cultural Transformation (OPCC & CT) established the Integrative Health Coordinating Center in 2013 in order to help overcome barriers to implementation of these services, including proper hiring codes, billing codes, credentialing and privileging, and there are still significant barriers including proper funding and access to resources. Creating strong partnerships with community resources is essential. OPCC & CT works collaboratively with the VHA offices of Mental Health and Primary Care to promote use and research of evidence-based CIH services, and is engaged with seven VA facilities as a part of a whole health pilot program. Many of these sites will look at how to work with their patients who may utilize outpatient clinics or live in rural areas, and how to promote whole health and deliver complementary services and education in those situations.

I am concerned about the discrepancy between State and VA mental health credentialing. In last year's Omnibus package, this Committee passed language acknowledging that the VA is reluctant to hire mental health counselors and marriage and family therapists who meet all educational, licensing, and examination requirements to practice in their States, but whose degree is from an institution not accredited by the particular organizations VA recognizes.

Question: I know that we gave you 180 days to report back on the implementations of hiring plans for this group of practitioners – but I was wondering if you could tell me about it now. How do you think easing the credentialing restrictions within states could impact the sickening suicide epidemic within the veteran population?

VHA Response: Beginning on September 28, 2010, VA facilities were authorized to hire Licensed Professional Mental Health Counselors (LPMHCs) and Marriage and Family Therapists (MFTs) as specialty mental health providers. This was after Congress recognized LPMHCs and MFTs as a specific occupational category of mental health specialists in the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 109-461). It is important to note the qualification standards for

each core mental health profession require that an individual in that discipline graduates from a program that is accredited by an approved accrediting body that accredits training programs in that discipline. This rule applies to all VA core mental health disciplines (Psychology, Psychiatry, Social Work, Nursing, Licensed Professional Mental Health Counseling, and Marriage and Family Therapy). Thus, the standards for MFT and LPMHC graduate program accreditation are similar to and no higher than the standards for graduate program accreditation for other mental health professions in VA.

The qualifications standard for the LPMHC and MFT professions were developed by groups of highly-qualified subject matter experts (SME), leadership within VHA Mental Health Services (MHS), and VA's Office of Human Resources Management. The VA qualification standard for LPMHCs includes the basic requirement of 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 (CACREP). CACREP requires 60 hours of coursework in what they define as eight CACREP core areas: Human Growth and Development; Social and Cultural Foundations; Helping Relationships; Group Work; Career and Lifestyle Development; Appraisal; Research and Program Evaluation and Professional Orientation and Ethics. The qualification standard for the MFT profession requires that an individual have graduated from a program that was accredited by Commission on Accreditation for Marriage and Family Therapy (COAMFTE). COAMFTE is a specialized accrediting body that accredits master's degree, doctoral degree and post-graduate degree clinical training programs in Marriage and Family Therapy throughout the U.S. and Canada and since 1978, has been recognized by the U.S. Department of Education as the national accrediting body for the field of Marriage and Family Therapy.

When the MFT and LPMHC qualification standards were developed, the SMEs reviewed all current industry standards and practices and included consideration of all state requirements. Requiring a COAMFTE or CACREP accredited degree assures VA that the MFT or LPMHC has undertaken a superior course of professional preparation and that the individual has been trained in the appropriate knowledge and skill areas required of the profession. Additionally, the standard was developed to ensure the provision of the highest quality of care to our Nation's Veterans.

The addition of LPMHCs and MFTs to the VA mental health workforce has expanded VA facilities' staffing options and enabled VA to better meet the needs of a Veteran population increasingly in need of mental health care services. This cadre of professionals is part of an interdisciplinary team providing clinical services to Veterans who are affected by mental health disorders. These professionals provide screening of Veterans, mental health evaluations for diagnosis, treatment planning, and behavioral health interventions. They may treat a wide range of serious mental health issues, including post-traumatic stress disorder (PTSD), substance abuse, and other mental health concerns.

As VA's demand for mental health professionals grows, we expect that VA will continue to successfully recruit LPMHCs and MFTs into its mental health workforce. In order to

attempt to increase the number of MFTs and LPMHCs hired throughout the country, VA has engaged in an active education campaign to encourage facilities to hire MFTs and LPMHCs. During the education campaign, facilities have been asked to address what barriers (if any) contribute to hiring MFTs and LPMHCs. The facilities' mental health leadership has not expressed concerns that the existing qualification standards are a barrier to hiring MFTs. VA does not believe that the existing LPMHC and MFT qualification standards are preventing VA from hiring qualified candidates, and thus does not plan to change the qualification standards. It is important to understand that LPMHCs and MFTs are still a relatively new profession within VA and decisions to hire into this occupation are made at a local level, so the pace of hiring of this profession may vary from site to site. As many mental health leaders in the VA are not as familiar with the LPMHC and MFT professions and may not be aware of the roles that LPMHCs are able to serve, VHA MHS has presented to VISN and facility-level mental health leadership and local human resources staff about the benefits of hiring LPMHCs and MFTs and has provided a detailed Power Point presentation about the LPMHC and MFT professions. These presentations include information that LPMHCs and MFTs are considered one of the "core mental health professions" within VA.

Another manner, in which VA Central Office is supporting local LPMHC and MFT hiring efforts, is by creating clinical training opportunities. In FY 2016, VA awarded 18 pre-degree LPMHC internship positions to 7 VAMCs. For FY 2017, VA awarded 3 pre-degree MFT internship positions at one site. The Office of Academic Affiliations (OAA) anticipates a further expansion of MFT and LPMHC training programs in FY 2017 to further assist with VA's future workforce needs.

The fiscal year 2017 budget requests \$567 million for substance abuse, an increase of only \$9 million from fiscal year 2016 and a decrease of \$57 million for your estimate of last years. Drug abuse is a serious problem in our society and our Veteran population is no exception. Opioid and heroin abuse especially in rural areas— like the district that I represent — are on the rise. I want to be sympathetic to the vets that have chronic pain, but there is no denying the correlation between the over prescription of pain killers and drug abuse.

Question: Is there any VA initiative to ensure that VA patients aren't being needlessly prescribed these highly addictive drugs?

VHA Response: The Opioid Safety Initiative (OSI) addresses the risks of opioid analgesia comprehensively through a system-wide program with the following aims that include management of Veterans with co-morbid pain and mental health conditions:

- To reduce risks, such as high opioid doses, co-prescribing of benzodiazepines for anti-anxiety, close monitoring of Veterans with urine drug screens, and Veterans with risks such as substance use disorders and PTSD;
- To encourage the use of psychological, physical and Complementary and Alternative Medicine therapies such as acupuncture and yoga in pain

management and mental health conditions when they are co-morbid with pain; and

- To provide feedback and educational support for our clinical teams caring for patients with co-morbid pain and mental health disorders;

VHA has embarked on a system-wide program of education and training in pain management, opioid safety, access to alternative medical and non-medical treatments for pain, and patient education in self-management.

As a result of this initiative, safer prescribing practices are being used in VHA. Despite a large increase in the number of Veterans receiving care in the VHA, fewer Veterans are now prescribed opioids, fewer Veterans are prescribed high doses of opioids, fewer Veterans are prescribed opioids and benzodiazepines together, urine drug screens are more routinely used, and access to non-medical treatments has increased.

Below are the results of key clinical metrics measured by the OSI: From Quarter 4, FY 2012 (beginning in July 2012) to Quarter 1, FY 2016 (ending in December 2015):

- 141,206 patients are receiving opioids (679,376 patients to 538,170 patients);
- 47,746 patients are receiving opioids and benzodiazepines together (122,633 patients to 74,887 patients);
- 97,496 patients on opioids have had a urine drug screen to help guide treatment decisions (160,601 patients to 258,097);
- 112,846 patients are on long-term opioid therapy (438,329 to 325,483); and
- The overall dosage of opioids is decreasing in the VA system as 16,864 patients (59,499 patients to 42,635 patients) are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing.

The desired results of the Opioid Safety Initiative have been achieved during a time that VA has seen an overall growth of 107,342 patients (3,959,852 patients to 4,067,194 patients) that have utilized VA outpatient pharmacy services.

Question: Is there anything that might place pressure on a VA doctor to write a prescription for pain killers?

VHA Response: It is VHA policy that the provider will make decisions on pain management, with input from the Veteran, that are in the best health interests of the Veteran and following state and Federal laws and good ethical practices. OSI includes a system-wide program of education and training in pain management, in particular related to opioid safety, and also access to alternative medical and non-medical treatments for pain and patient education in self-management. With better training and education, providers are empowered to make better pain care decisions that reduce or avoid reliance on opioid medication to achieve pain management goals.

Providers are being trained in a more personalized, proactive, and patient driven approach to health care, including motivational interviewing techniques to better

understand the needs and desires of Veterans, address their health care goals, engage their patients, and motivate them to implement alternatives to opioid medication for pain care. The educational efforts of OSI include the Veteran and their families/caregivers in addition to VA providers, and therefore are particularly important in avoiding any pressure on the VA provider that may be perceived as coming from the patient to prescribe opioid pain medication that is not medically indicated for the Veteran.

I think we, especially those on this committee, have done everything we can to ensure the VA has the resources you need to invoke positive change. We've seen the reports and the headlines of the few bad actors within the VA. I'm worried that you're encouraging a culture that says that VA employees can get away with this kind of behavior – either they get moved to another VA facility or are placed in a different position. Without a system of accountability, we will continue to see the repeated problems persist no matter the budget that we provide to the VA.

Question: What are you doing to ensure that we are no longer shuffling poorly performing VA officials within the VA system?

VA Response: Secretary McDonald has stated publicly many times that he believes strongly in creating and maintaining a culture of sustained accountability within VA. As part of VA's accountability process, allegations of misconduct by a senior leader are investigated by VA's Office of Accountability Review (OAR). VA employees are considered senior officials by OAR are the following: members of the Senior Executive Service, Title 38 SES equivalents, or Senior Level employees; members of the facility and network leadership teams in VHA (including Network Directors, Deputy Networking Directors, Medical Center Directors, Associate and Assistant Medical Center Directors, Chiefs of Staff, and Nurse Executives); Regional Office Directors, Area Directors, and Deputy Directors in VBA; Cemetery Directors and Memorial Service Network Directors in NCA, and GS-15 program office and regional office heads within the staff offices and staff organizations, as well as all positions centralized to the Secretary of Veterans Affairs. OAR conducts administrative investigations to identify evidence and determine, among other things, the appropriate level of culpability. VA Directive and Handbook 0700 cover the administrative investigation process. If, following an investigation, VA determines that there is evidence to support a disciplinary action, VA determines the level of discipline in accordance with case law and VA policy, which includes VA's table of penalties. In summary, where there is evidence of poor performance or misconduct, VA takes appropriate action.

Question: Has the VA's relationship with its employees union played a role in this? Last year, you testified that 65% of VA employees were union members, what union demands affect or hamper your ability to invoke change?

VA Response: VA management has the sole responsibility under the Federal Service Labor-Management Relations Statute (Chapter 71 of Title 5) to determine the appropriate level of discipline. In accordance with case law and VA policy, those decisions must be appropriate, consistent, and in the Federal government's best interest. If the employee, who is subject to discipline, is a bargaining unit employee

(i.e., represented by a labor union), the parties have negotiated in their master collective bargaining agreements reasonable and expeditious due process appeal procedures. Similar due process rights are available to employees not in the bargaining unit.

Question: What role do union representatives play in the VA's disciplinary process?

VA Response: The decision to propose or issue a final discipline decision is exclusively a management decision. Bargaining unit employees have the right to respond to proposed discipline (due process) or to grieve or appeal final disciplinary decisions through the negotiated grievance procedures or through the procedures established by the Merit Systems Protection Board. The union serves as the exclusive representative in the negotiated grievance procedures.

Question: Do you think the union demands are at cross-purposes with your intention of bringing on the 'best and brightest' to oversee such an expansive healthcare system? Would the union demands on salary create significant trade-offs in hiring?

VA Response: The unions share VA's interest in hiring and retaining the best and brightest for the VA workforce; however, hiring is exclusively a management responsibility. From the decision of what source to use for hiring, to the selection of the candidate, hiring is a management decision. The procedures for considering internal candidates for internal consideration of bargaining unit positions have been negotiated with the unions through our collective bargaining agreements.

Salary is not a negotiable item with the labor unions and does not create significant trade-offs in hiring.

The Honorable David G. Valadao
House Subcommittee on Military Construction and Veterans' Affairs
Department of Veterans Affairs Budget Hearing, Questions for the Record
3/2/2016

Scheduling

1. It is becoming clear that a major cause of the VA's ongoing backlog is the result of bad scheduling procedures. In an October 2014 report, the Northern Virginia Technology Council found that the VA's current scheduling procedures are insufficient and unable to meet the needs of America's veterans. A recent GAO Report on Wait Times confirmed this, and showed even more problems with scheduling, especially for mental healthcare. Last week, during a hearing before this committee, Deputy IG for the VA Linda Halliday stated that the VA needed to "tighten up" its scheduling practices.

Secretary McDonald, can you talk about the problems you see with the scheduling process and how this is delaying care for America's veterans?

Follow Up Question:

I understand the VA has undertaken an expensive project to upgrade their computer scheduling software, but how are you working to better the human element of schedulers working with our veterans?

VA Response:

CLERK'S NOTE: The VA was unable to provide a response in time for publication of the Hearing Record in July 2016.

Quality of Service

2. My office provides Central Valley veterans' services to help them navigate the VA. Last week, a constituent working with my office found out that a video conference request to appeal his case with the VBA was simply lost in the cracks. During our attempt to help him, we could not get a hold of anyone at the LA Regional Office, where the case was assigned. Instead we had to contact the Oakland office, which is always responsive. They told us that LA had his request from a year ago, but failed to attach it to his file. My constituent has now been waiting over a year and now must wait even longer. This is not an isolated incident and shows a breakdown in record keeping. It also discrepancy in the quality of service between regional offices. In the time since I discussed this case with the IG, the VA has

worked quickly to help the constituent out. But cases like this shouldn't require Congressional action to get the problem solved.

Mr. Pummill, why aren't there systems in place to make sure requests like this don't fall through the cracks?

Follow Up Question:

How can the VA better utilize best practices between regional offices to make sure quality of service is consistent?

VA Response:

CLERK'S NOTE: The VA was unable to provide a response in time for publication of the Hearing Record in July 2016.

Veterans Crisis Line

3. In a report released a month ago, the Office of the Inspector General found that calls to the Veterans Crisis Line were going to voicemail. Among many things, the report found that social service assistants in the call center were not properly trained to for that job. This line is supposed to be a pillar of the VA's effort combat veteran suicides. I had the honor to spend Christmas with our soldiers in Iraq, and during my time there the troops told me that 22 veterans commit suicide a day. The fact that our VA could let the Crisis Line go to voicemail and leave our veterans in distress is unacceptable.

Secretary McDonald, the VA has stated that this problem has been fixed. But how can something like this happen and who is being held accountable?

Follow Up Question:

Too many veterans are losing their lives to suicide, how can Congress work with you to reduce that number of 22 veterans a day?

VA Response:

CLERK'S NOTE: The VA was unable to provide a response in time for publication of the Hearing Record in July 2016.

[Questions for the Record submitted by Congressman Jolly for the Honorable Robert A. McDonald follows:]

Question: The Randolph-Sheppard Act, which creates opportunities for blind business owners, including Veterans, to operate vending facilities on federal properties is applicable to all properties controlled by the Department of Veterans Affairs. What steps has the VA taken to ensure compliance with the Randolph-Sheppard Act?

VHA Response: Currently, VA is successfully partnering with 27 Randolph-Sheppard Act (RSA) blind vendors. VA has been, and remains, willing to engage in collaborative efforts to increase business opportunities for blind vendors. For example, in discussions with the Randolph-Sheppard Vending Association from December 2003 to January 2005, VA proposed that many small Community-Based Outpatient Clinics not meeting the triggering criteria under the RSA might be consolidated for purposes of creating a vending operation or vending route, which a blind vendor could operate under contract with VA. However, VA received no requests for vending routes in response to its proposal. In June 2014, VA staff met with officials from the Department of Education, the National Federation of the Blind Entrepreneurs Initiative, and the National Council of State Agencies for the Blind to discuss opportunities in general, to increase the number of blind vendors in VHA facilities.

Unlike most Federal agencies, the operation of vending machines on VA property is governed by two statutes, the Veterans Canteen Service Act (VCS Act), 38 U.S.C. § 7801-7810, and the RSA, 20 U.S.C. § 107-107f. The VCS Act directs and authorizes the Secretary to establish canteens to make available quality and low-cost merchandise and services where it is deemed "necessary and practicable" for the comfort and well-being of Veterans hospitalized or domiciled in VA hospitals and homes, their families, relatives, or other visitors, and Department personnel. The primary goal of RSA is to provide employment opportunities to the visually impaired by requiring Federal agencies, including VA, to give priority in certain circumstances to appropriately licensed and trained blind vendors to operate vending facilities, where feasible, on Federally-owned or occupied property. Likewise, VA's VCS provides employment resources for Veterans, such as hiring them to learn and manage its vending operations and providing other training and employment opportunities in vending or supply chain management operations for Veterans participating in VA's Compensated Work Therapy program. Each statute has a complementary goal, and VA takes seriously its obligations under both. Consequently, VA compliance with the RSA may result in the co-existence of VCS and blind vendor operations at the same location. This is the case in 12 of the locations referenced above.

To carry out its statutory mandate, VCS offers food, retail, essential sundries, consumables, and vending machine services in VA facilities nationwide. To preserve the authority and ability of VCS to operate for the needs of our Nation's Veterans, Congress specifically exempted vending machines operated by VCS in accordance with the income-share provisions of the RSA.

VHA policies and procedures for RSA compliance are set forth in VHA Directive 1037. In accordance with RSA and VHA policy, VHA provides notification to the appropriate State Licensing Agency (SLA) when all of the following criteria are met:

1. an agency undertakes to occupy a building (to be acquired by ownership, rent, or otherwise), construct a new building, or substantially alter or renovate an already occupied building;
2. the building contains at least 15,000 square feet of interior space to be used by the Government; and
3. 100 or more Federal employees must be located in the building during normal working hours.

VHA's Office of Capital Asset Management, Engineering and Support communicates directly with VA entities to ensure that SLAs are notified when space construction or acquisition triggers the RSA. Notification takes place at least 60 days prior to occupancy and includes an opportunity to determine whether the space to be occupied includes a satisfactory site for a vending facility. VA is not required by law to offer space when the triggering criteria are not met, but VA welcomes ongoing dialogue with SLAs to discuss initiatives to increase opportunities for blind vendors, while maintaining the viability of VCS operations.

[Questions for the Record submitted by Congressman Bishop for the Honorable Robert A. McDonald follows:]

FY 2017 Budget Request

Question: The VA is requesting an additional \$1.7 billion for medical care in 2017. Is the VA purposely underfunding priorities in the advance and using the "second bite" to fix problems that should be budgeted for. Can you explain how priorities are set in the advance request and what metrics you are using for the "second bite?" And will we continue to see the "second bite" grow every fiscal year?

VA Response: The Advance Appropriation allows VHA to avoid the functional limitations of operating under a Continuing Resolution or disruption to operations in the event of a government shutdown. Funding the advance appropriation allows VHA an initial budget to continue high-priority programs until the full appropriation amount is signed into law. The "second bite" is intended for the administration to fully evaluate the resource requirements of the VA in context of the entire Federal budget. Cost circumstances can vary significantly from year to year, such as the Enrollee Health Care Projection Model, Hepatitis C drugs, Commission on Care recommendations, and the Sequestration cap. Each of these circumstances is re-evaluated by the Administration during the President's Budget cycle.

Question: The Veterans Experience Office (VEO) was established as part of the MyVA Task Force under the Office of Enterprise Integration (OEI). Up until now, VEO activities have been funded through OEI reimbursements. However, the FY 2017 budget proposes to make the VEO a stand-alone office within the General Administration appropriation and requested \$72.6 million in funding and 204 Full Time Equivalents (FTEs) via direct budget authority. Why would the Department not continue to fund this office from reimbursements and use the requested funding for other priorities? Is this another layer of bureaucracy?

VA Answer: The Veterans Experience Office (VEO) is not an additional layer between Veterans and VA leadership. It is new organization that is performing a function that has never been performed before. The Veterans Experience Office (VEO) will bring to VA capabilities in customer insight and human centered design that are used by great service companies in the private sector. VEO creates a new and much-needed ability to understand Veterans' needs and the extent to which VA products and services meet those needs. This includes understanding the true "root causes" of Veterans' greatest pain points. Drawing on these quantitative and qualitative insights, VEO partners with VA's operational lines of business to design scalable, system-wide interventions. VEO implements those interventions at the facility level throughout the country, and at the enterprise level on VA's customer-facing digital platform (vets.gov, now in beta version) and at VA national contact centers. VEO brings the capability of assessing the effectiveness of these interventions in improving Veterans' experience with VA,

identifying opportunities for further improvement.

As a new function and Department priority, we believe VEO should be funded separately in the Budget at a level that provides visibility for proper oversight. To “jump start” VEO, reimbursable funds from the Administrations have been used in FY 2015 and FY 2016. To fund VEO, Administrations and Staff Offices reduced or deferred other operations that otherwise would have been executed. With the time to fully plan, begin executing the VEO mission, and to provide for a clearly defined organizational VEO structure, it now best serves Veterans and the taxpayers to establish a separate budget line item for these new services.

Question: What are you doing to ensure future leadership will not affect these initiatives that have begun to spark significant change in the Department? Additionally, how much money have you spent on MyVA thus far?

VA Answer: The goal of MyVA is to transform VA’s culture and processes in how the Department serves Veterans and their families. MyVA is not a one-time set of initiatives that will either be implemented or not in the future, but a new culture and values-based thinking that is being infused into everything VA is doing. The changes and initiatives that are currently taking place are becoming everyday practices. Once transformation initiatives are integrated into the system, and the Veterans’ and employees’ experiences improve, VA believes the momentum of MyVA will be so great that future leaders and employees will want to continue a system that puts Veterans at the center of everything the Department does.

MyVA spent \$35.9 million in 2015, to stand up the MyVA Program Management Office and create several initiatives, including customer data integration to ensure that Veterans can interact with one system, rather than many, in providing information for benefits and services.

In FY 2016, the estimated amount for MyVA/VEO spending is \$79.3 million, which includes the stand-up of the VEO Central Office, implementation and set up of District offices, identification and implementation of MyVA Shared Services initiatives, and establishment of a MyVA Program Management Office in the Office of Enterprise Integration.

Board Veterans Appeals (BVA)

Question: The current appeals process is complicated and ineffective, and Veterans on average are waiting about 5 years for a final decision on an appeal that reaches the Board of Veterans’ Appeals, with thousands waiting much longer. The budget proposes to simplify the Appeals process through legislation and provide additional resources toward this effort. Regarding the authorization, it is unclear if the authorizers are going to take this proposal up. What benefit is the increase to the BVA appropriation if the accompanying legislation is not enacted?

VA Response: A decision not to provide full funding for the Board of Veterans Appeals (Board) at its request for \$156 million in FY 2017 is a decision to not adequately and appropriately serve our veterans. The Board currently manages an antiquated appeals process that is failing our veterans and taxpayers. To reduce the wait time a veteran faces in this appeals process Congress can: 1) enact the simplified appeals process that VA has sent to the Congress (which includes additional resources in the near term to eliminate the backlog of appeals), or 2) invest significant resources over many years into an inefficient and broken system. Without increased funding for the Board and the Veterans Benefits Administration, staffing levels and the number of decisions each year will remain static, as there is a direct correlation between the number of Board employees and the number of decisions for veterans. Without legislative changes in combination with increased appropriations, the appeals backlog will continue to grow, reaching record levels as the number of incoming appeals increases. VA has proposed a simplified, streamlined, and fair appeals process, so that 5 years from now, veterans would have appeals resolved within a year of filing. This is in stark contrast to the current wait time of almost 3 years, or 5 years for appeals that reach the Board. The initial investment to reach the 365-day goal begins with funding the FY 2017 Budget request in order to work down the current inventory of about 440,000 benefits-related appeals.

Question: It appears that this proposal will limit a Veteran from updating his file as it goes through the process. Will the Veteran still be able to submit additional information or is there a cutoff point under this new proposal? Also were the Veterans Service Organizations consulted and did you get buy-in from them before you released this proposal with the budget request?

VA Response: VA has engaged Veteran Service Organizations (VSOs), state and local government officials, and other stakeholders in an open, honest dialogue about what it would take to provide veterans with a timely, fair, modern, and streamlined appeals process. The 2017 President's Budget includes a number of proposals that, if enacted and resourced, would enable the Department to provide most veterans with an appeals decision within 1 year of filing an appeal. While the technical legislative proposals included in the 2017 President's Budget that support this proposal may appear broad, none of the proposals are set in stone, and the Department remains open to alternative solutions that would allow VA to reach the same goal. Although the specific proposed legislative language is still under development, our reform concepts have been summarized in the FY 2017 Budget. In addition, we engaged in a 3-day Appeals Summit Lockdown with the VSOs and other veterans' advocacy groups (from March 8-10, 2016) to identify common ground on a new appeals process, which has been followed by numerous subsequent engagements, including a full day of further discussion on March 30, 2016, with numerous exchanges throughout April. The Department is committed to partnering with all stakeholders to identify long-term solutions to provide veterans with the timely, fair, and transparent appeals process they deserve. The Board completed a draft of the red-line statutory language and words of enactment and shared this with Congress and the VSOs on April 1, 2016. A second draft was shared with Congress on April 11, 2016, which incorporated feedback from

the stakeholder group. The new appeals legislation provides all stakeholders the best opportunity to provide veterans with the most transparent and understandable claims and appeals process possible.

Question: The goal to eliminate the claims backlog by the end of calendar year 2015 was missed; however, there are a little over 70,000 remaining and that number is starting to tick back up. I know that you have suspended mandatory overtime which has led to this increase. My questions are is the 300 additional claims processors enough and are you concerned that without overtime, the backlog will spiral out of control again?

VA Response: Assuming there are no major changes impacting VBA's claims receipts (e.g., new presumptive entitlements, increased military discharges, etc.) or ability to complete rating claims (such as a court ruling), VBA expects the volume of claims pending more than 125 days to continue to decrease (with normal seasonal fluctuations due to holidays and increased leave usage) during the balance of fiscal year (FY) 2016 and throughout FY 2017. Overtime continues to serve as an effective tool to help reduce the inventory and the number of claims pending more than 125 days. VBA has allocated approximately \$47M in overtime for compensation rating claims in FY 2016 and plans to allocate a similar level in FY 2017. VBA's request for an additional 300 full-time equivalent employees in the FY 2017 President's Budget is for non-rating claims processors (i.e., not for compensation and pension ratings claims processors) to reduce the backlog of dependency and other non-rating claims.

Although additional focus has been placed on appeals and non-rating workload, VBA continues to prioritize rating claims to prevent the disability rating workload from pending more than 125 days. VBA's process improvements, such as the Veterans Benefits Management System and the National Work Queue (currently being deployed) are providing increased efficiencies in the claims process. By modernizing to an electronic claims processing system, VBA has significantly increased its productivity, with medical-issue production more than 82 percent above FY 2009 levels. VBA continues to build on the success of these initiatives and is maintaining this progress. VBA is confident that with our multi-faceted approach, including the use of optional overtime, as supported by the FY 2016 budget, efficient resource allocation, and system and process improvements, we will continue to improve service to Veterans.

Question: The break out for the claims backlog is a mixture of those applying for initial claims and those applying for supplemental claims. How does the VA prioritize those claims and will the VA ever get to a functional zero regarding the claims backlog?

VA Response: VBA has not defined "functional zero" for disability claims pending over 125 days, but VBA does recognize that some claims in the pending inventory will require processing beyond the 125-day standard to ensure that VA meets its legal obligations to assist Veterans in the development of their claims. VA considers additional evidence and/or new medical conditions throughout the claims process. However, late evidence or new contentions stop the momentum made in processing the

claim, since they usually require a new round of evidence-gathering, medical examinations, and analysis, thus prolonging the determination of a decision. As of March 31, 2016, 44,000 of the 79,000 claims pending over 125 days are supplemental claims. VBA does not differentiate between initial and supplemental rating claims; however, VBA prioritizes certain rating claims – our oldest claims, fully developed claims, and special interest claims (homeless, extreme financial hardship, former prisoners of war, terminally ill, etc.). VBA's published strategic target is to reduce the disability rating claims backlog to less than 10 percent of the total rating inventory by FY 2021.

Question: Mr. Secretary, it is my understanding that Vista Modernization is now taking a pause but this should not affect the interoperability, is that correct?

VA Response: The Department of Veterans Affairs (VA) interoperability efforts are on track, and unaffected by any pause. We certified interoperability with the Department of Defense (DoD) on April 8, 2016, as required by Section 713 (b)(1) of the 2014 National Defense Authorization Act (NDAA), approximately 8 months ahead of the requirement. Modernizing VA's Electronic Health Record (EHR) remains a top VA priority, as we work to ensure that clinicians have the right tools to serve our Nation's Veterans. The "strategic pause" that has been mentioned recently refers to our evaluation of plans for future delivery of EHR capability in VA. We are not pausing our current efforts to deliver new capabilities to the providers who are serving Veterans – that work is proceeding at full speed. VA is taking an impartial look at our EHR modernization efforts and ensuring that we have the right strategy in place for the future. Under Secretary for Health Dr. Shulkin and Assistant Secretary for Information Technology and Chief Information Officer Ms. Council are asking hard questions and thoroughly reviewing data to ensure that Veterans are best served by our efforts. This evaluation will help determine whether VA's EHR modernization efforts beyond FY 2018 will be focused on further iterations of Veterans Information Systems and Technology Architecture (VistA), commercial applications, or some combination of both.

Question: Has the money we appropriated for the modernization of Vista been a complete waste and what are your plans moving forward? Also, please explain how this will not affect interoperability?

VA Response: Our VistA Evolution expenditures have not been wasted. In fact, precisely the opposite is true. VA is delivering tremendous value to VA clinicians and Veterans through VistA Evolution. Our VistA Evolution investments have enabled us to develop a modern, robust, clinical data exchange pipeline with DoD using national standards identified by the Office of the National Coordinator for Health IT and the DoD-VA Interagency Program Office. DoD and VA share near real-time visibility of interoperable data between our EHR systems as a result. As of June 12, 2016, over 138,169 VA staff have access to the Joint Legacy Viewer, up from fewer than 900 just 18 months ago.

The cornerstone of the VistA Evolution Program is the Enterprise Health Management Platform (eHMP), which provides important new capabilities for Veteran-centric, team-based, quality-driven healthcare. eHMP is an intelligence platform that overlays VistA and could overlay other EHRs. The longitudinal record for each Veteran aggregated in eHMP is fully interoperable with Department of Defense and other health record systems supporting national standards identified by the Office of the National Coordinator for Health Information Technology (ONC). The read-only version, eHMP 1.2, is expected to complete installation in product accounts at all sites before the end of the summer and will start testing by a limited number of clinicians. In the third quarter of 2017, it is expected eHMP will be broadly deployed and offer basic capabilities for writing notes and ordering tests. It will also offer significant new capabilities such as 1) closed-loop tasking with escalation for team-based management and communication 2) consults with improved communication and tracking, 3) customizable workspaces that provide more efficient understanding of information about a condition or clinical workflow, and 4) pilot tools for pro-active monitoring of safety and quality and more rapid improvement of technology and clinical practice. eHMP will gradually replace VA's CPRS as the front-end interface for future VistA clinical applications and enhanced/modernized legacy packages. eHMP will also enable VA to meet the FY 2014 NDAA Section 713 Generation Level 3 EHR requirement, delivering evidence-based medicine at the point of care. Additional VistA Evolution deliverables will provide value to Veterans and clinicians by enabling electronic prescribing of medications, secure messaging between VA health IT systems with enterprise messaging infrastructure, modern access management capabilities, and critical enhancements to our pharmacy and scheduling systems.

[Questions for the Record submitted by Congresswoman Lowey for the Honorable Robert A. McDonald follows:]

Question: I am concerned that the 2015 solicitation for the influenza vaccine was arbitrarily and narrowly tailored to only allow limited numbers of pharmaceutical companies to meet eligibility. Why does the VA solicitation require pre-filled syringes, particularly since this requirement benefits foreign companies over American jobs? What is the VA doing to ensure that American companies who manufacture domestically are provided with equal opportunity to provide influenza vaccines to the VA?

VHA Response: When determining the requirements used by the National Acquisition Center for the flu vaccine solicitation, VA takes several factors into consideration, first and foremost being safety and efficacy. When safety and efficacy are comparable between products, VA also considers other factors such as dosage forms, storage requirements, and expiration dating in order to increase operational efficiencies.

VA follows the Department of Health and Human Services, Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) guidelines for flu vaccine product selection. The most current version notes that the guidelines apply to all licensed influenza vaccines used within Food and Drug Administration (FDA) indications. The only area where ACIP notes additional recommendations for specific products outside of the FDA labelling for these vaccines is for the use of live attenuated influenza vaccine in special populations. This indicates that ACIP deems the other vaccines clinically equivalent for most of the population.

In the case of the 2015-2016 influenza flu vaccine solicitation, the majority of VA's requirements were for prefilled single dose syringes. This preparation is advantageous to providers in the field because it avoids the need to separately purchase syringes and needles to administer the product, and it saves time for VA providers, allowing more patients to be vaccinated, because it does not require the extra time needed to draw doses out of a vial before administering.

[Questions for the Record submitted by Congressman Farr for the Honorable Robert A. McDonald follows:]

Question: When can we expect the VA to provide detailed information to the Army on the lease for the joint VA DoD Gourley Clinic?

VA Response: VA and DoD reengaged on the sharing of healthcare resources and space at the facility in late March. Since that time, various communication has occurred and information shared, and VA continues to work closely with DoD as the project unfolds and construction heads towards completion later this calendar year.

Question: What is the timeline for fully implementing the Plan to Consolidate Community Care?

VHA Response: The full implementation of the Plan to Consolidate Community Care is dependent on Congressional action on legislative changes, resources and funding.

Even if needed resources are provided and legislative and regulatory changes are made, transitions of the magnitude described in the plan take years to design and implement; therefore, the plan is organized into three phases. Phase 1, lasting approximately one year, would focus on the development of minimum viable systems and processes that can meet critical Veteran needs without major changes to supporting technology or organizations. In Phase II, also lasting approximately one year, VA would enhance the changes implemented in Phase I through interfaced systems that will appear seamless to Veterans and community providers, but would largely continue to employ existing infrastructure and technology. Phase III would be a multi-year effort that will include the deployment of integrated systems, maintenance and enhancement of the high-performing network, data-driven processes, and quality improvements.

Question: The Committee has urged the VA, for the last two years, to broaden their certification process and accept qualified applicants from state recognized MFT programs. Why is the VA beholden to one certification process instead of working with other certification organizations to expand the number of behavioral health providers who could work for the VA?

VHA Response: With respect to the certification of Marriage and Family Therapy providers, 38 U.S.C. 7402(b)(10) requires they hold a full, current, and unrestricted license to independently practice marriage and family therapy in a state. VHA policy is consistent with this requirement. In addition, VHA Director 1027, *Supervision of Psychologists, Social Workers, Professional Mental Health Counselors, and Marriage and Family Therapists Preparing for Licensure*, clarifies the duties and responsibilities of staff who are licensed independent practitioners and serve as clinical supervisors to

psychologists, social workers, professional mental health counselors, or marriage and family therapists who are not yet licensed to practice at the independent level.

Community Care providers of medical care must meet licensing requirements of their particular professions in the state where the services are provided. If licensure is not required in the state, the provider must be certified in the appropriate national or professional association that sets standards for the profession for the requested medical services.

Question: What is the VA doing to shorten the waitlists for veterans to receive treatment for drug addiction?

VHA Response: VHA is hiring additional staff and utilizing purchased care to provide treatment for drug addiction. VA efforts have included specific funding for hiring Addiction Medicine specialists to expand medication assisted treatment (MAT) access in under-served areas; clinical mentorship programs to support newly trained providers; a technical assistance program consisting of monthly webinars and email consultation; and on-going management monitoring, attention, and action planning regarding meeting needs for MAT services. As a result, VA has substantially expanded access to MAT from just fewer than 12,000 patients in FY 2010 (27.3 percent of those diagnosed with opioid use disorders) to more than 20,000 patients in FY 2015 (29.6 percent of those diagnosed with opioid use disorders). VA also continues to work to expand MAT access in locations with lower capacity or barriers to access to services (e.g. rural areas), including through innovative models such as group practice visits and telemental health models. Prioritization of expansion of MAT services is encouraged by the inclusion of MAT access measures on leadership performance plans and as part of VA's Psychotropic Drug Safety Initiative.

Question: What resources do you need to update and expand drug treatment programs so veterans can receive treatment immediately?

VHA Response: While VA offers substance use disorder (SUD) services at all of its health care systems, in some locations, the services are too far away or otherwise difficult to reach for Veterans who need care. Additionally, there are some locations where demand currently outpaces capacity. As such, Veterans diagnosed with SUDs who live in some counties are much less likely to receive SUD services than Veterans who live in counties closer to core treatment programs. The estimates below assume there is no additional physician capacity within VA currently to provide these services, which we know varies by facility. In order to eliminate geographic disparities in access to SUD treatment:

- In FY 2015, VHA provided medication-assisted treatment to 21,915 patients. To increase access to MAT, assuming a conservative treatment use rate of 33 percent of patients with a diagnosed opioid use disorder when access is readily available at the county level, an additional

6,000 existing Veteran patients would require MAT for opioid use disorders. Conservatively assuming that each new physician hired would provide care for the maximum patient limit of 100 patients, 60 new physician full-time equivalent employees (FTEE) would be required.

- At a use rate of 40 percent, which is consistent with the current use at multiple VA facilities, 88 new physician FTE would be required.
- In FY 2015, VHA provided intensive outpatient SUD treatment to 39,450 Veterans. To increase access to intensive outpatient SUD treatment, assuming a conservative use rate of 7 percent, an additional 15,057 existing Veteran patients with diagnosed SUD would require treatment. Assuming the minimum staffing of 2.5 clinical and 0.5 administrative FTE and average length of stay of 4.6 weeks, an additional 290 FTE would be required.
 - Assuming a use rate of 10 percent, which is consistent with current utilization at multiple VA facilities, 540 additional FTE would be required.
- To increase access to psychosocial services for Veterans with SUDs, assuming a conservative use rate of 36 percent, an additional 26,904 existing Veteran patients with diagnosed SUD would require treatment. Assuming an average caseload of 50 patients and a 33 percent retention rate, an additional 177 clinician FTE would be required for regular outpatient treatment.
 - Assuming a use rate of 40 percent, which is consistent with current utilization at some VHA facilities, an additional 40,021 existing Veteran patients would require treatment, and an additional 264 clinician FTE would be required.

Notably, these estimates only account for SUD services needed by Veteran patients who were already diagnosed and seen for a SUD. Challenges to access to care are also likely to decrease the likelihood of having SUDs identified and diagnosed. Therefore, as services are expanded into currently underserved areas, we expect that additional unmet needs will be uncovered.

We expect that the Veteran population as a whole has additional unmet SUD treatment needs. Estimates from the National Survey on Drug Use and Health suggest that 16 percent of the 7 percent of Veterans with a SUD do not receive needed treatment for their SUD. This would suggest that 242,800 Veterans have a SUD that is currently untreated. If this population were to seek care from VHA, then substantial additional treatment capacity would be needed.

Question: What is the VA doing to expedite reimbursements to veterans for medical expenses they are paying out of pocket, particularly emergency expenses that are reportedly taking months, if not years, to address?

VHA Response: VA Community Care (VACC) program staff processes claims for emergency medical expenses as soon as possible. When a Veteran submits a claim to VA for consideration for payment, the local VACC program reaches out to the provider to obtain the necessary information to adjudicate the Veteran's emergency claim. If the claim satisfies the requirements of the law, 38 U.S.C. 1728 or 1725, the local VACC program office pays the community provider, and if the Veterans has paid expenses out of pocket, the local provider is notified they must reimburse the Veteran for the amount the Veteran paid.

In addition, VACC program leadership and supervisors monitor timeliness and quality across the claims processing enterprise daily. VACC uses a tool called the Claims Processing Dashboard, which was developed in August 2015. This tool helps leadership strategize and focus efforts to achieve the optimal results by prioritizing impactful and aged claims for processing, and monitoring productivity. This is helping facilities make great progress on aged claims.

Denial or delay of a claim can happen for a number of reasons and, we give providers necessary information to remedy issues. This information includes claim filing instructions, an explanation of common reasons claims are denied, and copies of the Preliminary Fee Remittance Advice Reports (PFRAR), which lists all the claims processed for payment, rejected, or denied; and the reasons for disapproval of payment. The PFRAR is sent to individual providers and provides the status of their claims submitted for processing.

Question: What is being done to more expeditiously provide reimbursement to non-VA caregivers participating in the CHOICE program?

VHA Response: Effective March 1, 2016, the contracts with Health Net and TriWest were modified to decouple the requirement to submit medical documentation from the payment of claims for care provided under the Veterans Choice Program (Choice) established by the Veterans Access, Choice, and Accountability Act of 2014. The removal of this requirement has expedited payments to Choice providers. Claims processed increased from under 100,000 a month before the implementation, to over 200,000 a month starting in March 2016. In addition, VA's Chief Business Office (CBO) continues to work with contractors and their prospective provider management teams to address Choice provider issues such as nonpayment. The work continues to evolve as obstacles these providers face are addressed by both CBO staff and contractor staff. Common trends in nonpayment are analyzed and reported to the contractors to assist the contractors in developing a strong outreach program to providers to help avoid similar obstacles to timely payment in the future.

VA continues to work with Choice program providers and the contractors to mend relationships by assisting to remove barriers facing the Choice program providers. During this effort, CBO has developed a Community Care Response Team to work

escalated provider issues. One of the team's focus is to maintain and continue to build healthy relationship between VA, Choice providers, and the contractors, including payment related issues.

Question: How is VA recruiting CHOICE providers despite the poor reputation that has subsequently resulted in providers dropping from the program or declining to participate at all?

VHA Response: VA's Third Party Administrators are taking the necessary steps to proactively reach out to potential providers as necessary. One of the most important ways in identifying potential providers is through Veteran feedback. As the most important stakeholder in the VA health care system, VA is dependent on Veterans' input in identifying quality community providers. When Veterans identify a provider they wish to see, the contractor contacts the provider and begin the process of registering as a Choice provider or joining the network. If the contractor is unable to work with the provider to become part of the network, VA staff will contact the provider and help alleviate any concerns the provider may have about joining the network, working toward a resolution that will be beneficial to our Veterans.

VA Medical Center (VAMC) representatives are also working jointly with contractors to conduct provider meetings focused on providing program details to key community care vendors and high-volume community care vendors. These meetings foster communications with and education of large and small community care entities, and support the process of provider enrollment under Patient-Centered Community Care and increase agreements to participate as Choice providers.

Additional efforts to increase Veterans' access to community medical resources include outreach letters to 22,264 TRICARE contracting entities encouraging community participation in the VA Choice Program. These letters were sent to key decision makers at health care entities in the areas where TRICARE North overlaps with VA Regions one, two, and four. Communication has also been sent to the 7,650 community providers currently listed on what is called the VA Nomination Report. These providers were identified by the local VAMCs as key community resources providing medical care.

Question: Veterans in the 20th district are expecting the garrison flag from the former Ft. Ord to be flying at the new Gourley clinic upon its completion. In what ways can the restored Garrison Flagpole be safely incorporated in the outside landscape of the VA?

VHA Response: The current Garrison flag pole at the Monterey Clinic site has been in place for approximately 80 years. It has been worn down by the elements and needs a new foundation (concrete footing). At this time, there has been no attempt to repair the Garrison flag pole, and there are no current plans for its installation. Installation of the Garrison flag pole would require an estimated \$200,000 for restoration, siting, lighting, and foundational work. Additionally, the Garrison flag pole is approximately 100 ft. tall compared to the standard 30-ft. tall poles that have been ordered for the Monterey

clinic. Raising and lowering the flag on a daily basis would require several staff due to its size.

Question: What is VA doing to assess and open up hiring for positions that are unnecessarily limiting the assessment of eligible applicants?

VA Response: Each VA facility conducts recruitment based on the needs of the organization. Facilities use a variety of recruitment sources based on the particular vacancy and anticipated available applicant pool. At times, positions are announced internally to provide advancement opportunities for current VA employees. When positions are announced outside the VA workforce and open to current Federal employees, preference eligible Veterans who are external to VA are permitted to apply and be considered for the announcement. In some cases, for non-Senior Executive Service (SES) positions, negotiated labor agreements require facilities to initially announce vacancies internally, and to make selections from the pools of well-qualified applicants who apply from within the facility before making selections from the external pool of qualified applicants.

The Veterans Health Administration (VHA) has taken several steps to re-engineer its recruitment process to fill Medical Center Director (MCD) and Network Director positions with qualified applicants by:

- Engaging Senior Leadership throughout the entire recruitment process,
- Creating and implementing new recruitment procedures to expedite or streamline the recruitment process, and
- Leaning the SES recruitment process to reduce redundancy and help speed up the hiring process.

VHA has streamlined the SES recruitment process by utilizing nation-wide recruitment announcements to fill multiple MCD positions at various locations. This effort has provided VHA a great opportunity to simultaneously fill multiple positions across the country, reduce redundancy in recruitment efforts, improve customer service, and improve hiring timelines for making selections for MCD positions.

VHA has implemented HR community best practices to reduce hiring time frames; utilize recruitment authorities, such as non-competitive hiring under Title 38 and Veteran hiring authorities; and provide reporting tools, which assists HR in identifying barriers within the recruitment process.

VHA has increased net onboard staff by over 17,000 employees since the beginning of FY 2015 (through February 29, 2016). This includes over 6,000 nurses (registered nurse, licensed practical nurse, and nursing aide), 1,550 physicians, 112 psychiatrists, and 450 psychologists.