

U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2017

HEARING

BEFORE THE

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

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U.S. DEPARTMENT OF VETERANS AFFAIRS BUDGET REQUEST FOR FISCAL YEAR 2017

Wednesday, February 10, 2016

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

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Radewagen, Brown, Takano, Titus, Ruiz, Kuster, O'Rourke, Rice, McNerney, and Walz.

OPENING STATEMENT OF JEFF MILLER, CHAIRMAN

The CHAIRMAN. Good morning. This hearing will come to order. Mr. Secretary—

Secretary McDONALD. Good morning.

The CHAIRMAN [continued].—thank you for being here with us today. We are gathered to receive the President's VAs budget recommendation for fiscal year 2017, as well as the advanced appropriation recommendation for fiscal year 2018. As everybody knows, the budget request came out only yesterday, so admittedly, there is a lot for everybody in this room to digest.

Mr. Secretary, I am told you have come with charts today to help us in that effort. And we thank you in advance, for the visuals that you provided for us to be able to understand you a little more clearly.

Let me briefly outline some areas that I would like for you to cover for us in more detail this morning. First, I think there is general agreement among Members of Congress that you Mr. Secretary, and veteran organizations, that greater reliance on outside care providers is absolutely essential to providing high-quality care for our veterans.

The Choice Program got off to an uneven start, if you will, for a plethora of reasons, but the basic concept behind its inception still holds true today, namely veterans shouldn't be forced to travel or wait for a VA appointment if a community option is available to them. And if that option exists, it should be the veteran's choice, not the VA's choice as to whether or not they can exercise that option.

The \$10 billion Choice Program fund will more than likely be depleted within the next fiscal year. We have asked for and received

a plan from VA to consolidate all of VA's outside care authorities into a new Veterans Choice Program going forward.

We are aggressively working the legislation to make the program a reality, and I know that is something that is very important to you, Mr. Secretary.

I am also interested to know what the cost assumptions are in the budget for the new Choice Program for the next two fiscal years, and how it can be paid for, given the current fiscal constraints that exist here in Washington.

I am also interested to see what impact greater reliance on outside providers is actually having on wait times. Simply adding more capacity within VA and opening up additional outside care options doesn't seem to have moved needle yet much, because as the Secretary has told us, demand from existing and new users of the system has overwhelmed whatever new capacity is being created.

This is an issue that the Commission on Care is evaluating, and we will get the Commission's recommendations later this summer, but we need to make sure that what changes we are putting forward not only work, but are fiscally sustainable, and that they also lay out the groundwork for what the VA health delivery system will look like 20 years from now.

Second, I think it goes without saying, I have been pretty critical of VA touting its claims of backlog reduction success because it really, I think, has ignored the experience of veterans whose waits have grown longer in other areas of the claims process.

The growing appeals backlog is a glaring example, and I am glad the Secretary has put forward an idea for a large-scale structural reform, instead of simply throwing more money staffing over the next decade. I put forward a similar reform proposal in concept, so I am interested in hearing more from the Secretary this morning about his ideas.

Thirdly, the conversation we are having on the budget wouldn't be complete if we didn't discuss VA's stewardship of taxpayer dollars over the last year. As my Ranking Member knows, we cannot have a hearing in this room without discussing Denver.

It was a botched construction project. We know that it is going to be close to a billion dollars over budget. The department has spent millions of dollars on art projects, relocation benefits, bonuses for failing employees.

And last July, the agency threatened to shut down hospitals within weeks, due to a budget shortfall that actually was kept internal in the preceding months, forcing Congress to give the department access to an additional \$3 billion, all of which came out of Choice.

In classic fashion, I am not aware of a single employee that has been held accountable for any of these unprecedented failures. And I will continue to fight to ensure that VA has the resources that it needs. But given some of the problems, this budget request is going to continue to receive every bit of scrutiny that I think the American taxpayers would expect us to give it. It is the very least we can do for our veterans and the taxpayers and our country.

And, finally, I would be remiss if I didn't mention my frustration, and I am sure many of the frustrations shared by my colleagues

on this panel, of the recent string of Merit Service Protection Board decisions overturning disciplinary actions proposed by VA Deputy Secretary Sloan Gibson. We have got to have an honest conversation about what is happening within the Civil Service system.

As the deputy noted in his statement last Friday after the most recent MSPB decision, and I quote, "It appears that the MSPB does not agree with the Congress or the VA's interpretation of the extent of my authority, and has once again substituted its judgment for mine and demonstrated a willingness to second guess the VA's application of legitimate high standards for accountability," end quote.

I will let the deputy's strong statement speak for itself, but needless to say, there is a massive problem here that permeates the entire conversation about the resources that VA has. Absent accountability, we are doomed to see repeated problems persist no matter the budget that we provide to the VA, no matter how much the Secretary tries to make the changes at the VA.

VA's mission of serving veterans is second to none in our government. Creating a higher standard for performance because of that mission, is what the public expects of each of us. And I remained committed to working with you, Mr. Secretary, on how we can strengthen the system of accountability within the department, and across the Federal Government system. It is imperative to everything, you and we, will attempt to accomplish for veterans.

Mr. Secretary, before I turn it over to the Ranking Member, I would like to take a moment to compliment you and your staff for the work that you all did in producing the final master plan for the West Los Angeles Campus. I visited the campus a few weeks ago and saw the enormous potential for the restoration of the property, and the mission of any future tenant of the property, to its original purpose of serving the veterans.

You brought a lot of competing interests together who, not long ago, were extremely far apart. Considering the potential, the West LA Campus has, in helping homeless veterans in the Los Angeles area, to reintegrate into society. I salute you and the leadership that you have shown.

And with that, I recognize the Ranking Member, Ms. Brown, for her opening remarks.

OPENING STATEMENT OF CORRINE BROWN, RANKING MEMBER

Ms. BROWN. Thank you, Mr. Chairman.

Mr. Secretary, I want to thank you and thank the President. During this President's tenure, discretionary spending has increased 86%. I think that deserves repeating. During President Barack Obama's tenure, discretionary spending has increased 86%. What this says is this President just doesn't talk the talk. He walks the walk and as one veteran group says, he rolls the roll.

The President is doing his part to take care of veterans. I believe that this budget provides us with a starting point to begin the process of making sure that veterans are getting the benefits and service we have promised them.

I look forward to discussing your proposal to establish an additional appropriation account focused on community care, especially in light of your repeated requests for budget flexibility.

I want to be assured that this account will not take our focus away from providing the VA with the resources it needs to provide health care to our veterans.

In light of the shortfalls, VA faced last year, and the uncertainty of reform efforts, I want to ask you, Mr. Secretary, the question I ask every year, does this budget give you what you need to accomplish your mission?

Do you believe that there are areas that need a special focus and may need additional dollars?

I stand ready to do whatever I can to make sure you have what you need. But while I will be in the front line of fighting for the dollars you need, I want to make it very clear, I expect you to spend every dollar we give you wisely for our veterans.

I believe we must focus on our veterans. By focusing on our veterans, we will begin the process of rethinking how we ensure that we keep our promises to them in the years ahead.

So let us know what you need, and we will, working together, on both sides of the aisle, make sure you have the tools and the dollars to accomplish your mission.

And as I close, failure is not an option. It is not. We are going to take care of our veterans. And with that, I yield back the balance of my time.

[THE PREPARED STATEMENT OF CORRINE BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Ms. Brown.

I would like to welcome our first panel to the table this morning. Accompanying the Honorable Robert McDonald, Secretary of Veterans Affairs, this morning is the Honorable Dr. David Shulkin, Under Secretary for Health; Mr. Danny Pummill, Acting Under Secretary for Benefits; Mr. Ronald Walters, Interim Under Secretary for Memorial Affairs; the Honorable LaVerne Council, Assistant Secretary for Information Technology and Chief Information Officer; and Mr. Ed Murray, Interim Secretary for Management and Interim Chief Financial Officer.

I appreciate all of you being here today. I appreciate also your willingness to engage the Committee Members when we have questions and issues that come up outside of this room. Your openness with us is greatly appreciated.

Mr. Secretary, you can proceed with your opening statement. Members, the Secretary has requested and we have granted 15 minutes this morning for the Secretary's opening statement.

STATEMENT OF THE HONORABLE ROBERT A. MCDONALD

Secretary MCDONALD. Thank you, Mr. Chairman.

Chairman Miller, Ranking Member Brown, distinguished Members of the Committee, thank you for this opportunity to present the President's 2017 budget and 2018 advanced appropriation request for the Department of Veterans Affairs.

Mr. Chairman, ten of our top 16 executives are new since I became secretary, all with substantial business experience. Their

fresh perspectives combined with our more experienced government and health care executives are catalyzing innovation, meaningful change, and opportunity.

Our leadership team today is comfortable with and actually invites honest, sometimes tough discussions about transforming VA. With me here on the panel, everyone is new to position since I was sworn in as secretary with the exception of Mr. Walters.

I have a written statement that I ask to be submitted for the record.

The CHAIRMAN. Without objection.

Secretary McDONALD. Thank you, sir.

The President has proposed \$182.3 billion for the department in fiscal year 2017. We think it is a strong budget, another tangible sign of the President's devotion to veterans and their families.

The President's proposal provides the funding needed to enhance services to veterans in the short term, to transform VA's systems to better serve veterans over the long term, and to support and sustain progress that we have made toward any disability claims backlog and veterans homelessness.

It supports VA's four agency priority goals, to improve the veterans' experience with VA, to improve VA's employee experience, to improve access to health care as experienced by the veteran, and to improve the dependency claims process.

It also sustains our commitment to end veterans' homelessness, improves programs for veterans' care in the community, streamlines and reforms the appeals process, advances medical and prosthetic research, strengthens veterans' benefits programs, and proposes increased budget flexibility.

It supports our five MyVA transformational objectives to modernize VA's culture, processes and capabilities, and to put the needs and the interests of veterans and their families at the center of everything we do.

Improving the veteran experience is our first and primary strategic objective of the MyVA transformation. It is important that every contact between veterans and the VA will be predictable, consistent, easy, and outstanding.

Second, making things better for veterans by improving the employee experience. We have no hope of improving the veteran experience without also training and improving the employee experience.

Third, we want to improve internal support services and bring our IT infrastructure into the 21st century to enable employees and leaders to better serve veterans.

Fourth, we want to establish a department-wide culture of continuous improvement that would be undergirded by Lean Six Sigma.

And, fifth, we want to expand strategic partnerships, extending the reach of services available to veterans and their families. And then we will also continue to support our 12 MyVA breakthrough priorities that improve the delivery of timely care and benefits to veterans.

My written submission addresses these breakthroughs in detail, but I would like to quickly show you how the proposed budget supports these priorities for veterans. And I think we all agree on this.

First, the 2017 budget proposal will provide \$2.6 million for the MyVA program office to help integrate all the MyVA initiatives across the enterprise. It increases by 47 percent funding for our veterans' experience office so we can continue training field employees on advanced business skills, sharing best practices, and establishing high customer service standards, and requests \$171.3 million for IT systems that are instrumental to improving the veterans' experience.

In support of our priority effort to increase access to the point that veterans' clinical needs are addressed the same day, they call or visit primary care facilities at a VA medical center. The budget requests \$65 billion for veterans' medical care. That is a 6.3 percent increase over 2016. And it proposes \$66.4 billion in advanced appropriations for the VA medical care programs in 2018. That is a 2.2 percent increase above the 2017 level.

The proposed budget provides an expected 35,000 veterans access to hepatitis C treatment. It funds tele-health access and it enhances health programs for women veterans. And \$7.8 million is provided for mental health which continues to support successful mental health care related prevention programs.

We are committed to making sure that when veterans call for new mental health appointments they receive suicide risk assessments and immediate care if needed. Veterans already engaged in mental health care who need urgent attention will speak to a provider the very same day.

The 2017 budget includes \$12.2 billion for care in the community. It includes a new medical community care budget account consistent with the VA budget in the Choice Improvement Act.

Proposed IT investments will fund veterans' enterprise-wide integrated services platform with best in class service and satisfaction measures and expand veterans' access to self-service tools and benefits information. Veterans should have access to VA systems and know where to get accurate answers 24 hours a day seven days a week.

The 2017 request supports this priority by funding veteran contact centers in the field and veterans' crisis line modernization. To expand veterans' access to benefits they have earned and deserve, the proposed budget supports increased contracted disability exams at all regional offices.

And it proposes a simplified, streamlined, and fair appeals process so most veterans could have a final appeals decision within one year of filing. With your support, five years from now, veterans could have a process that resolves 90 percent of their appeals within one year.

To that end, the proposed budget requests a 42 percent increased in Board of Veterans Appeals funding to \$156 million and a 35 percent increase in board staffing to more rapidly address the growing inventory of more than 440,000 pending appeals.

Under this plan by 2022, we could reduce appeals FTEs to a sustainment level sufficient to process all simplified appeals within one year. The simplified process makes sense for veterans and it is an excellent return on investment for taxpayers too. The proposed sustainment level is 1,135 FTEs fewer than the fiscal year

2016 budget requires and 4,070 fewer department-wide than necessary to address the appeals workload with FTE resources alone.

The fiscal year 2017 proposal continues our progress toward an effective end to veterans' homelessness by focusing on proven prevention and treatment services and veteran homelessness programs like SSVF, HUD-VASH, grant per diem, home loans, and foreclosure prevention.

It provides services to about 65,000 homeless veterans or those at risk. It prevents an estimated 36,000 veterans and their family members from becoming homeless and provides case management support for over 63,000 who receive HUD-VASH vouchers.

It is no coincidence that the very best customer service organizations are almost always among the best places to work. So the proposal provides for the training that supports our MyVA transformation.

In the same vein, the proposed budget will help us significantly improve critical staffing levels that balance access and clinical productivity and reduce time to fill standards so we can move quickly to hire the people that veterans need to serve them.

With the funding requested, we can continue transforming our IT infrastructure to create a world-class IT organization supporting veterans and our business partners and to do the work necessary to build an enterprise-wide, integrated medical surgical supply chain that leverages VA's scale to increase responsiveness and reduce operating costs, were redirected to priority veteran programs over \$150 million in cost avoidance savings from transforming our supply chain.

The proposal includes \$78.7 billion in discretionary funding. That is \$3.6 billion above the 2016 enacted level largely for health care. It includes \$103.6 billion in mandatory funding for veterans' benefits programs. For the second time, the budget request VBA advanced appropriations. A hundred and three point nine billion is requested to fund compensation and pensions, readjustment benefits, and veterans' insurance and indemnities for 2018.

And the 2017 proposal fully funds construction. These are investments in the future and they are critical to providing both quality care and timely benefits and first-rate facilities that are safe for veterans and VA employees.

We will continue to work closely with the U.S. Army Corps of Engineers, our construction agent, to execute two projects over \$100 million.

So with this budget, there is a lot we can change on our own and we are doing that now. But many important priorities that will make meaningful differences for veterans require Congress to act on behalf of veterans.

You will find more than 100 legislative proposals in the budget. Over 40 of them are new for this year, some absolutely critical to even maintain our current ability to purchase non-VA care. Here are just a few of the most important ones.

First, in this session of Congress, we can make significant improvements to set the foundation for top-to-bottom transformation and streamlining the VA's care in the community programs based on proposals in VA's landmark road map plan set out in our Octo-

ber 30th report to make these programs more rational and to better serve veterans.

Second, the budget proposes a general transfer authority that allows me some measured flexibility to transfer up to two percent of discretionary funding across accounts excluding medical care to address emerging needs and overcome artificial funding restrictions on providing veterans' cares and benefits.

Third, it is critical that VA is competitive with the private sector for top health care talent, so we are proposing flexibility on the maximum 80-hour pay period requirement for certain medical professionals. The private sector has this flexibility and it makes sense in running a hospital. This flexibility can both improve hospital operations and help attract the best hospital staff who use and prefer more flexible schedules.

Along the same lines, we are proposing critical compensation reforms for network and hospital directors. Other adjustments to VHA personnel authorities we are putting forward also reflect common sense and good practice and best practices from the private sector.

Fourth, we need your help to change VA's purchase care authorities, provider agreements, and individual authorizations, so veterans have access to clinically indicated and timely care. Failing to address this requirement in the weeks and months ahead impacts potentially thousands of veterans receiving care from local non-VA doctors, hospitals, nursing homes, and state veterans' homes.

Fifth, we are looking for congressional authorization of 18 leases submitted in VA's 2015 and 2016 budget requests as well as authorization of eight major construction projects included in VA's 2016 request. And we need your support for the six additional replacement major medical facility leases, two major construction projects, and four cemetery projects in the 2017 budget.

Six, passing special legislation for VA's West Los Angeles Campus will get positive results for veterans in that community, especially veterans most in need after years of debate and court action as the Chairman said.

Seven, finally as I implied, we have to change the current appeals process. Last year, the board was still adjudicating an appeal that originated 25 years ago. The appeal had previously been decided by VA more than 27 times. Conceived over 80 years ago, it is unlike any other standard appeals process across the federal and judicial systems. It is complex, it is confusing, and it is ineffective.

Under current law without significant change in resourcing, pending appeals are projected to soar by nearly 400 percent to almost 2.2 million by 2027. Together we can do this and we are open to ideas from the Committee and veteran service organizations to make it work for veterans.

If we are serious about changing VA and better serving veterans and their families, we can't keep kicking the can down the road. 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, but we have to be courageous and we have to work together to make that so.

This is my second budget cycle and I appreciate the support that you have all shown to veterans, the department, and our MyVA

transformations. On behalf of veterans and the VA employees serving them every single day, thank you for this opportunity. Mr. Chairman, I look forward to your questions.

[THE PREPARED STATEMENT OF ROBERT A. McDONALD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Secretary.

According to the slide deck that VA provided yesterday, you anticipate spending \$1.7 billion in the fiscal year on the Choice Program and we discussed this a little bit yesterday.

How much money is left in the Choice Program today or close?

Secretary McDONALD. As we talked yesterday, Mr. Chairman, we expect the Choice Program funding to run out before the budget year 2018. We will get you the exact number here.

Mr. MURRAY. I have that here.

The CHAIRMAN. If you would turn the mike on. Thanks.

Mr. MURRAY. Thank you.

So our estimate for the Choice Program for Section 801 for 2016 is \$2.7 billion and under 802 where we provide care in the community, it's \$1.7 billion. In 2017, we estimate spending of \$969 million for Section 801 and \$4.8 billion in Section 802. And that rounds out the 10 and the 15 together and we can provide you the details.

The CHAIRMAN. And you anticipate exhausting the funds when?

Mr. MURRAY. At the end of 2017.

The CHAIRMAN. So could you explain, and, again, we discussed this a little yesterday, but can you explain the discrepancy that VA states that the Choice utilization has markedly increased in fiscal year 2016 and the low dollar figure presented in the budget materials? In other words, why are Choice expenditures estimated to be more than three times higher for 2017?

Mr. MURRAY. Go ahead, Dr. Shulkin.

Dr. SHULKIN. Mr. Chairman, as you know, and I think that you characterized this correctly, the Choice Program got off to a rocky start. We have been working very hard to get veterans access to care through Choice and we have seen the results of that. We are seeing increased authorizations in significant numbers and that is leading us to the projections that we will be spending much more money using Choice funds to serve veterans.

The CHAIRMAN. The advanced appropriation requested for fiscal year 2018 is nearly \$2.5 billion short of the 2017 request and almost a billion dollars short of what was actually paid in fiscal year 2015.

So how does the VA envision addressing the inevitable budgetary shortfall that is out there?

Secretary McDONALD. As we talked yesterday, Mr. Chairman, I think what we are going to need to do is to come back with the work that we do in the consolidation of care in the community and come back with what we think the number will be for 2018.

Really the top priority for us is getting to that consolidated program. As you know, in the consolidation plan that we put forward, there were a couple options that we laid out for the Committee. One was dealing with the emergency room. One was also dealing with what we think could be incremental demand from more veterans using the system.

What we have seen already and you reflected this in your remarks is veterans already have a choice. Eighty-one percent of veterans have some form of Medicare, Medicaid, private health insurance. And as we continue to improve the care from the VA and the care in the community, more veterans are going to choose to use our system because our co-pays are zero.

And right now our estimate is the average veteran uses the VA for only 34 percent of their care. If that increases one percentage point, it is about a one and a half billion dollar increase. So we need to get a better handle on this as we work together on the consolidation of care in the community.

The CHAIRMAN. I think that the Committee was pretty clear and the Congress was with the Choice Fund Program was intended to supplement VA's community care budget. However, I saw in the budget where it is assuming \$7.2 billion for community care funds which are distinct, should be distinct from Choice funds. And that is less than what you had budgeted and spent in each of the fiscal years 2013, 2014, and 2015.

So my question is, do you think that VA is compliant with the intent of the Congress when the law was passed?

Secretary McDONALD. I certainly think so.

Ed, do you seen any—

Mr. MURRAY. I don't. I did want to mention that we will get a chance in the next year this time to revisit the appropriation for 2018. So I just wanted to put that in there once the consolidation and the care in the community recommendations are made, we will get an opportunity to review our numbers for fiscal year 2018.

Secretary McDONALD. And, again, Mr. Chairman, I think the most important thing is—we got to get the consolidation of care in the community law passed and decide what is going to be part of that, if the change in the emergency room structure is going to be part of that, and then, we got to decide what the demand is going to be. And we will work with you on future budget numbers that will go with that.

The CHAIRMAN. And we would like to have a little extra time to talk to you about what our assumptions are, and why we think there may be an issue, whether it is a deviation, and maybe we can all get back on the right track.

I have one more real quick question. The major and minor construction requests are substantially lower than what you requested last year. And I understand that is because we are waiting for the study for the Joint Commission to come out later this summer. And I think that is the appropriate thing to do.

The 800 pound gorilla, if you will, is going to be if they recommend closing underutilized facilities. Are you prepared, Mr. Secretary, to full throatedly support that? Obviously you will have to ask for our help as well.

Secretary McDONALD. Mr. Chairman, as you know, for the two last years, I have had in my written budget proposal productivity improvements for the department. And I have specifically culled out ten million square feet of unused space that results in a charge to the taxpayer of \$25 million a year. And we have a number of these facilities where we need the courage of the Members of Con-

gress to help us close them, so that we can turn those savings into productive use of funds for veterans.

The CHAIRMAN. Thank you very much.

And Ms. Brown just said she has some facilities she would like to put up on the chopping block, so I will yield to her.

Secretary McDONALD. Whose district is it in?

Ms. BROWN. Mr. Chairman, all I said was just as long as it is not in my district, but I know every single Member feels that way. We support that. And please don't charge that against me.

I have a couple of quick concerns. That was a wonderful conference you had last week on suicide prevention. And I want to thank you for that.

But one of the things we learned, 22 a day servicemembers commits suicide, which is totally unacceptable, but only three of them are in the VA's system. What is VA doing to get those veterans into the system and have you included that in your budget?

Secretary McDONALD. Yes, ma'am. Actually, what we said was 22 a day and 17 not connected to the VA system, so five. As you pointed out, if we can get people connected to the VA system, we know how to treat them and we know how to prevent suicide. So outreach, as you described, becomes a very big issue.

And I will let David talk about what we are doing.

Dr. SHULKIN. Well, first of all, thank you for personally being there and to the Chairman and so many members that came because we know this is very important to you and very important to us.

This conference, as you know, was focused on this exact issue, how do we get people that are isolated and not seeking help back in. And what we essentially believe is, we need the help of the community. VA can't do this alone. So we had at this conference community groups, the Department of Defense, many other organizations that we believe we need to work closer with.

And the essence of this is, is that what we learned is, we need to do a better job in the transition time. When a military member leaves service and then gets in the VA, we need to make that a much more thorough process to get people help.

We also have learned that we can do better in predictive tools using big data analysis and using the research that is actually done at VA to predict who is at greater risk. So we are working on that and we are coming up with a plan 30 days from the conference with very specific actionable steps that we are going to put into place.

Ms. BROWN. Let me add that women, one of the fastest growing groups of the military, are committing suicide, and I hope VA is targeting our female veterans, making sure that they get the help that they need.

Secretary McDONALD. We are. In fact, since the year 2000, the number of women veterans seeking VA health care has skyrocketed from 160,000 to 447,000. So we are putting in place all kinds of programs which we can talk about, whether it is having designated women's health providers at all of our facilities or whether it is having a hundred percent of our medical centers with women's advocates, having women's clinics, having obstetricians, gynecologists.

We really have to transform the entire VA system to serve our female veterans and that is a big effort for us.

Ms. BROWN. And one more thing, the elderly veteran, the Vietnam veterans are committing suicide as well. Most people think it is the younger veterans, but it is really the older veterans. So I am hoping VA is looking into that.

I have one other quick question. We had a hearing last week about Hepatitis C and what we are doing as far as the pharmaceuticals. And I know at one time that we wanted the VA to work with the Department of Defense on the formularies so we could keep that cost down for all of the people we service.

Can you give me an update on that issue because the cost of the drug pharmaceuticals is unacceptable particularly since we put the money up front?

Secretary McDONALD. Our plan, the plan that you have got here is to eliminate hepatitis C amongst veterans over about a five-year period. We are in negotiations. There are alternative drug treatments now and we are in negotiations to get those costs down as low as we possibly can. And any savings we turn up, we will obviously plow back into the budget to better care for veterans.

Dr. SHULKIN. I would just add with the Department of Defense, we are coordinating purchasing our drugs together. And we are using the Federal Government size and scale to be able to get the best prices for taxpayers.

Ms. BROWN. In closing, the VA and HUD need to work closely together. In talking to lots of the homeless facilities, part of the problem is the definition of the voucher. We don't want veterans to be under a bridge before we can intervene and provide proper housing and health care. So we need to work together with those inter-agencies to make sure that VA is doing the best thing to prevent homelessness.

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

The CHAIRMAN. Yes, ma'am.

Mr. Lamborn, you are recognized.

Mr. LAMBORN. Thank you, Mr. Chairman.

Mr. Secretary, I am very upset about the IG report, this report that came out on the clinic in Colorado Springs last Thursday. And I know you are here to talk about the \$182 billion budget, but I have got to ask you about my district as referred to in this report.

According to your testimony, looking at all appointments nationwide in fiscal year 2015, quote, "More than 97 percent of 56.7 million appointments were completed within 30 days of the clinically indicated or veterans' preferred date."

But according to this report which looked at appointments at the clinic in my district also in fiscal year 2015, only 36 percent of veterans were able to get an appointment within 30 days. There is 100,000 veterans in my district. Thirty-six percent is a lot worse than 97 percent.

So either the 97 percent number you give us is unreliable, or veterans in my district are getting extra poor treatment. Which is it?

Secretary McDONALD. As you know, Congressman, and I know Deputy Sloan Gibson talked to you about this last Friday, this report from the IG is about a year old, almost a year old. And as a result, we have taken many steps since this report was issued.

The clinic manager has been replaced. Sixteen additional schedulers have been hired and we have consolidated training and supervision and accountability. The bottom line is that since March of 2015, Colorado Springs has been aggressively implementing the Choice Program. Wait times are coming down. We obviously have more work to do, but this report is about a year old.

Mr. LAMBORN. Well, as for accountability, will anyone in the future be fired or can we say that anyone was fired? Heads need to roll when something like this happens.

Secretary McDONALD. Well, first of all, when I read the report, what came out of the report to me was we did not do a good job training people, not that there was malfeasance. I know in your letter, you said deliberately falsified appointment records to prevent these veterans from receiving care, intentionally delay the medical care of our Nation's veterans.

I read the report. I didn't see that. I mean, it is in your letter, but I didn't see it in the report. I think if you read the report closely, the IG did not make any kind of accusations about people falsifying records or doing anything like that.

Mr. LAMBORN. Well, I did review the report closely. And we had that conversation, Secretary Gibson and me, but here is what the IG report says. It says scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days. Now, maybe it wasn't done maliciously, but—

Secretary McDONALD. Well, see, your letter again says intentionally delayed the medical care, deliberately falsified appointment records. That is not what is in the IG report.

Mr. LAMBORN. Okay. When it says scheduling, the IG says scheduling staff—

Secretary McDONALD [continued]. The people were poorly trained. They were poorly trained and we admit that. And as I said, the clinic manager has been replaced. We have hired 16 additional schedulers. We have also consolidated training and supervision. This is a training issue and—

Mr. LAMBORN. Well—

Secretary McDONALD [continued].—we are after it. And that is why the care has improved, but we need to go further.

Mr. LAMBORN. Whether it was done maliciously or not, I think the records were falsified and I think that that is a correct term to use. And I think someone needs to be fired for this.

The person that was let go, was that person actually fired or were they just allowed to be transferred or allowed to retire?

Secretary McDONALD. Mr. Chairman, maybe we should make the IG report a matter of the record so that the American people can read this because the investigation makes no such accusations.

The CHAIRMAN. It is already publically available now on the IG's Web site, Mr. Secretary.

Secretary McDONALD. Yes, sir.

Mr. LAMBORN. Let me ask you about the Veterans Choice Act. We talked with someone out of this same part of Colorado who said she did not agree with the Choice Program and quote, "The VA will always take better care of veterans than the community and that the community is not capable of taking care of our veterans."

Mr. Secretary, I perceive widespread defiance and resistance to the Choice Act. Is that something that we are going to still have to face in the future, or is there going to be a better attitude on the part of VA bureaucracy?

Secretary McDONALD. I don't perceive that, but we are going through a process right now called leaders developing leaders. It is a program that we put together to train all the leaders in the VA. We have trained over 12,000 leaders so far. Part of that training is basically sharing with everyone the vision that the optimal network of the future includes inside VA care and care in the community.

So if you find someone who you think doesn't understand that, please provide us the name and we will certainly share our vision with them. But I think everybody gets it.

The CHAIRMAN. Mr. Takano, you are recognized.

Mr. TAKANO. Mr. Secretary, you HAVE shared with Members of this Committee in a variety of formats your vision for moving the VA toward your vision of care in the community. I want to let you know I support what you are doing, and hopefully, we can all work together to make sure that we enable you to consolidate all of the various care in the community programs.

But I have some questions about some other parts of your budget and maybe you or your cohorts can help explain. 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 year.

Can you explain this change in estimate with the ever-increasing opioid addiction crisis facing our states?

Dr. SHULKIN. VA has prioritized the issue of substance abuse. There is no question about it that this is a growing problem. We have put together some new efforts to be able to address this. We think that the budget request that we have submitted will allow us to be able to focus on this and increase our efforts to be able to make an impact on this.

We have just joined a White House effort to be able to address heroin abuse in the rural areas that is being led by the Secretary of Agriculture that VA is participating in. We are working with other federal colleagues and other agencies to be able to help address this.

But we are very interested in doing more, and if there are other ways that you think that we should be stepping up or other ways to do it, we will use whatever resources we have to be able to address this.

Secretary McDONALD. I think I would say, too, that opioid use across VA, and, again, just the general average is down, and the use of alternative treatments, we are finding more and more successful, whether it is equine therapy, acupuncture, yoga. We will try anything in an evidence-based way that works and we are seeing great success with these alternative programs.

Mr. TAKANO. So you are noting a decrease in opioid abuse, but what about overall substance abuse?

Dr. SHULKIN. You know, as the secretary said, we have shown that we actually have 16,000 fewer veterans on prescribed opioids, so we are making progress there. We still have more work to do.

The illicit drugs being used and heroin are a national epidemic and unfortunately we are seeing that also increase in the veteran population.

So we need to be doing more and we are engaged in looking for ways to make our programs more effective and to do better outreach. VA has huge programs in substance abuse as you identified.

Mr. TAKANO. Well, how are you sharing your best practices throughout the VA?

Dr. SHULKIN. We are doing research that we publish on this and so that is available throughout. You know, once we publish it, it is available to the scientific community. We are holding conferences on this. We work with SAMHSA, the other federal agencies that are involved in substance abuse on a regular basis. We are working with the CDC on efforts in substance abuse as well.

But, you know, this is such a national epidemic and such a crisis for veterans that we are very open to new ways, new ideas to be able to effectively treat veterans.

Secretary McDONALD. And some of the work that we have done, I have actually spoken at groups, associations of doctors worried about reducing pain medication. I did one in West Virginia. I know David has done some. I have spoken to the American Medical Association. I have spoken to the Institute of Medicine.

We have got to play a leading role in using our evidence-based alternative therapies as ways to get people off of opioids and also to deal with the substance abuse issue that is national.

Mr. TAKANO. Well, I note that you are increasing your mental health budget significantly and perhaps there is some spillover there. But I want to—quickly before my time runs out—get a question in about, you know, the shortage of health care providers around the country and whether you believe your budget includes the resources that are necessary to maintain and expand the VA graduate medical education in order to recruit and retain health care professionals.

Secretary McDONALD. We do, but there is a critical piece of legislation that we are asking for help for, and that would be the 80-hour work week which will allow us to hire people into emergency rooms and work flexible schedules.

Also we are asking for Title 38 categorization for our medical center directors. Our medical center directors who are not Title 38 are paid roughly half of what is made in the private sector. As a result, we have a number of vacancies that we are trying to fill. So to be competitive, we need those pieces of legislation passed.

Mr. TAKANO. But as far as medical school education, though?

Secretary McDONALD. Medical school education, I have been to—

Mr. TAKANO. I mean, graduate medical school.

Secretary McDONALD [continued].—over two dozen medical schools recruiting. I find that our problem recruiting is not that difficult and that we are outreaching. Most of the medical schools will tell you they can increase their throughput, but that they need the residencies.

And I know we are in conversation with Dr. Roe right now and the Doctors Caucus at getting more resident positions that we can put against primary care, mental health, and in the rural areas because that is where the need is great in the country.

Mr. TAKANO. Okay. Thank you.

Dr. SHULKIN. Thank you.

The CHAIRMAN. Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it.

Welcome, Mr. Secretary. Thank you for your testimony. Also thank you for taking my call the other day with regard to the Wounded Warrior that needed assistance and thanks for following up. I really appreciate it so very much.

Mr. Secretary, again, the President's budget includes a request of \$7.8 billion for mental health programs and efforts. It is encouraging to hear that more and more veterans are utilizing the VA or DoD to treat their invisible wounds which has increased yearly again. However, the heartbreaking statistic is the 18 to 22 veterans taking their lives daily delves deeper into the discussion regarding the effectiveness of our current programs.

Does the VA track data regarding how many veterans that started VA programs to treat their mental health issues, finished the treatment programs and are the mechanisms in place to survey the veterans opinion on the successes and areas for improvement because one size does not fit all? And I understand that veterans start these programs and sometimes do not finish them and have nowhere to turn.

That is why it is very important that we get these alternative treatments at the VA on a regular basis. I want to ask you that question too. How many treatments, I know you brought it up, but how many complementary alternative treatment programs such as equine therapy, service dog therapy, yoga, what have you are there? Do our veterans have access to these programs on a regular basis?

And in my opinion, we need to expand these programs, and I filed legislation to do so. Of course, they must be evidence based, but I want to ask that question if you have again these programs within the VA, are we tracking them to see how many veterans finish those programs and how effective they are?

Secretary McDONALD. Yes and yes. We need to track these veterans very closely because the number one cause of missed appointments are people with mental health care appointments and so we need to track them very closely.

I am pleased to tell you that we had a situation in Vermont, White River Junction where we had a veteran not show up for an appointment and one of our nurses seeing that veteran didn't show up. Rather than following the rules, and we are talking about changing our organization from a rule-based organization, a principle-based organization, she contacted the VA police.

The VA police contacted the local police. They went around the house. They discovered there weren't footsteps in the snow. Neighbors hadn't seen this individual. They actually broke into the house and found this veteran lying on the floor wedged between two pieces of furniture. The person would have died if this nurse hadn't been tracking that appointment for that veteran.

We have celebrated that nurse's behavior. We have celebrated her principle-based way of operating. And it was my honor to celebrate both of them recently for what they did. And we are using

that as an example to all of our employees as to how we should think about the veterans we serve.

David.

Dr. SHULKIN. I would just, Congressman, you have identified a very, very tough issue in the treatment of mental health disorders. Our no-show rate for mental health appointments is 21 percent. So you are absolutely correct.

Mr. BILIRAKIS. That is unacceptable.

Dr. SHULKIN. Yeah, very, very difficult. This, of course, is the same thing that you find outside the VA system.

The VA is absolutely trying to target this issue of noncompliance. We are doing more than I have seen anywhere else. We use peer counselors to be able to help with this. We have our vet centers, 300 of them across the country as another source of a place to get information and bring back into the system.

But every one of our suicides we do what is called a root-cause analysis to look specifically at this issue. What could we have done better to bring people in? I was reviewing a root-cause analysis today where we actually walk the people over to the schedulers to make sure that they scheduled. We can't force them unfortunately to show up and that is where our noncompliance rate is, so—

Mr. BILIRAKIS. Are there mechanisms in place to survey, you know, to get the option of—

Dr. SHULKIN. Yeah.

Mr. BILIRAKIS [continued].—the veteran with regard to these programs if they are effective?

Dr. SHULKIN. This is what I would call research where we are looking at different ways to improve compliance. We have two facilities right now that are surveying veterans using functional scores every time they visit to look at this issue. We are trying to learn what works so we can spread that.

Mr. BILIRAKIS. Okay. We have a \$7.8 billion budget.

Dr. SHULKIN. Yes.

Mr. BILIRAKIS. Okay. How much is going toward these alternative and complementary treatments?

Dr. SHULKIN. Yeah, that would be outside. The alternative complementary treatments are in our patient center, a different medical services budget. And, again, VA has one of the largest programs of these integrated medicine or alternative medicine type facilities that we are continuing to learn what works and spread it throughout the system.

We have more to do because not every facility has access to this. The type of workers that are experienced and trained in this are somewhat limited, but we are continuing each year to bring more of these services to our facilities.

Mr. BILIRAKIS. Thank you very much.

And I guess my time has expired. Thank you, Mr. Chairman. Appreciate it.

The CHAIRMAN. Ms. Titus, you are recognized.

Ms. TITUS. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. I have a couple of issues. I will just throw them all out there and then ask you if you would please address them.

First and foremost, the appeals process, you heard it said so many times that I see this as a new tsunami that we need to try to address before it continues to get worse. And your figures are pretty compelling and that argument 440,000 currently taking 25 years. And I appreciate very much that you have given us a chart to simplify this process and that you have asked for additional resources.

I would ask you, though, of those 300 additional FTE, I think it is called non-related workload, how many of them will actually be our workforce? How many of them will actually be working on appeals and also when can we expect to get some specifics about the legislative changes that need—we need to make?

We talked and I appreciated that. And I have also reached out to the VSOs to say give us your recommendations because we need to get busy on the legislative side. And so we need some specifics on that.

The second thing I would ask you about is the medical research. You have in the budget \$663 million which is an increase of about \$33 million for medical research. And we have talked about this before, the need to do research on medical marijuana as an option. And I would ask you if any of that is scheduled to go for medical marijuana research and, if not, if we could work together to try to make that happen.

And then third, and this is something that is happening in my district, and I have brought it up before, about veterans' nursing homes. I realize that the VA provides grant money to the states, and then the states, through Medicare or Medicaid, are then responsible for them. But I wish we could look for some way for the VA to have a little more oversight of those nursing homes because some of them just really aren't operating up to standard and the VA doesn't seem to go back and check on them very often. And I wondered if there was somewhere that could go in the budget.

So those would just be my three areas of interest right now.

Secretary McDONALD. We will take them one at a time. We will start with appeals. Let me get some facts out on the table. So about 11 to 12 percent of veterans appeal their decision. Of that 11 to 12 percent, if you took the percentage of total, about two percent of veterans, two to three percent are responsible for about 45 percent of the appeals. So what is happening is you have people appealing and appealing and appealing. Some have appealed for 80 times. Some have appealed for multiple years.

We have had conversations with the veteran service organizations about what the change in law would look like, and we shared some thoughts yesterday with the Ranking Member and the Chairman. And this is going to take a team effort, and so we are going to have to all get together and decide what the change in law is.

We put a strawman in our budget proposal, but, again, it is just a strawman for people to react to. And we will be working that collaboratively over the time.

You asked how many people. Danny, how many people?

Mr. PUMMILL. The Congresswoman—for fiscal year 2016, you gave us 730 people to add to our non-rating work load, and we part a large number of those into the appeal process on the VBA side.

We have an additional 300—we actually hired them in 2015, so we get them hired and trained up to be ready to go in 2016.

The next batch, the 300, we are going to put 100 into appeals. On the other side, and the Board of Veterans Appeals, their budget was increased by \$46 million, and they are going to increase the number of judges and appellate people they have on their side to do that.

So the combination with the increased budget at the VBA, the increased people they are going to put on the job, the extra people that we are going to put on—on the VBA side, and if we can get some kind of reform, all that combined together, we think we can attack this problem and solve it.

Medical marijuana I will let David handle.

Dr. SHULKIN. Yeah, Congresswoman, I am not aware that VA is doing any research right now on the medical impact of medical marijuana. I would be glad to work with you on that issue. It is an important issue right now. We are not doing that.

On the state nursing homes, VA, as you know, funds this through a matching program, but does not have the responsibility for quality oversight. All that we have right now is a annual inspection. Again, if there are specific concerns on that, and you think that we should have a more active role in that, be glad to work with you on that.

Ms. TITUS. Well, thank you. I appreciate that. I would like to look at that. And I also think that as more and more states legalize medical marijuana and veterans do not have that as an option, we need to look at that, and if you think we need more testing—which I agree with—then we should be doing that testing.

And as for the appeals, we have got to get a legislative solution. Now, you can't just keep putting more people and and more money. That is not going to solve it. So Dr. Abraham and I are on that Subcommittee for disability. I appreciate working with him, and please keep us in the loop as you come with some of these suggestions, I would say.

Secretary McDONALD. Yes, ma'am, and as you know in my testimony, I actually talked about reducing the number of employees once we get this resolved with the law. Thank you.

Ms. TITUS. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Roe, if you would yield just for a moment, Ms. Brown has a question.

Ms. BROWN. Yeah, I have a question to the Secretary. My understanding under the medical marijuana, we, in Congress, prohibit you all from doing anything. Is that correct?

Secretary McDONALD. We are not allowed to prescribe medical marijuana. We can have—our doctors are permitted to have discussions with their patients in states where medical marijuana is legal about the use of medical marijuana, but we cannot prescribe it as an agency of the federal government.

Ms. BROWN. Thank you. I yield back.

Secretary McDONALD. Dr. Roe.

Mr. ROE. Yes and just for the record, on the medical marijuana issue, it is a sore spot with me. It ought to be studied like any other chemical, and it has not been. And you know, "I feel good," is not science. That's how you feel.

And so I think we need to study it like any other chemical. I totally agree that it is not science based. And so there is no science right now. I just reviewed this whole business of medical marijuana. There is no science about the medical marijuana benefit. So anyway, that is a different issue.

I wanted to bring up just a couple things very quickly to—a study was published just about three or four days ago that showed that death rates and re-admissions at VA hospitals for heart attacks, heart failure, and pneumonia were similar—it was in the JAMA—were similar, almost identical, to the private sector.

So I think it speaks that the quality of care the veterans get once they are in is comparable to the outside, and I think that is a shout out, and I think that is science right there. I think that what we need to do is make it easier. Obviously—and you are trying to, I think, Mrs. Secretary, for veterans to access the care there. So I think once they are in the system, the care is comparable. At least this study in JAMA definitely showed that.

Just two or three things I would like to talk about. One is homelessness. That is something to me, I think it has been an emphasis of mine since I have been here. I want to have you comment a little bit on that.

I think you mentioned about principal care, and I would just think that is putting the patient first. And that is what this nurse did, that is what nurses do. It is what doctors have done forever. And I think the system has prevented that sometimes from happening. And I think it is a shout out to this nurse, who just did not care what the system was. She cared about her patient. And I think that is what we need to have. That attitude needs to come from the top down, and I think it is beginning to.

So, first start with homelessness. We have discussed the disability backlog. Obviously, it is better than when I came seven years ago. There were a million claims when I came here and first sat on this Committee, so.

And the last thing I want to talk about is, I think it is critical for the long-term future of the VA, is the implementation of the VA residency programs and make sure we do that right. So I will stop.

Secretary McDONALD. I will start with homelessness and David can deal with the medical issues. On homelessness, we are making progress. I mean, homelessness, veteran homelessness, is down 36 percent since 2010. Unsheltered veteran homelessness is down 50 percent. That is all good. But we are getting to the point now where we literally know the veterans who are homeless by name. We literally know them by name. And as the Chairman said, and I appreciated his comment, the work that we have done in Los Angeles is largely about homelessness, because Los Angeles compared to other cities around the country is the place where there is virtually twice as many as you would find elsewhere. I mean, some of the cities who have claimed an end to homelessness have housed the number of people over a year that Los Angeles has to house in a month. I mean, it is that big of a problem.

And we were prohibited on our campus from doing extended-use leasing, which we do. We work with partners, private sector partners, who build residences for us. We have one in Palo—or Menlo Park, which is just, you know, not far from Los Angeles. So as soon

as we get that legislation, we are going to be working very, very quickly. Our master plan has a commitment for 1,200 beds in Los Angeles.

After Los Angeles it is San Diego. And what we are finding is the areas we need to work—and I will be quick about this—number one, is we need landlords to rent for the HUD VASH voucher amount, or we need to change the HUD VASH voucher amount. In Los Angeles, we have changed the amount twice.

Number two, we need developers willing to build these buildings for us, willing to get a rate of return on housing these homeless veterans. Number three, having the caseworkers to do the wrap-around care. We hired about 300 for Los Angeles.

So we are making progress, but there is still a lot of work that needs to be done.

Mr. ROE. What you pointed out is, is what we found, is the housing stock.

Secretary McDONALD. Yes.

Mr. ROE. And if you have a chance to visit, we will take you by some developers who have accepted what the HUD VASH Voucher pays and provide that housing stock.

Secretary McDONALD. Love to do that.

Dr. SHULKIN. Dr. Roe, I would just say I am very impressed that you are able to keep up with the medical literature. The study that you referred to in the Journal of the Medical Association was just released yesterday. It actually showed that VA has statistically better mortality for acute myocardial infarction and for congestive heart failure than the private sector, which I think has surprised a lot of people, but it does not surprise us, because consistently, VA has had either equal or better performance when it comes to mortality compared to the private sector. So thank you.

Mr. ROE. I yield back.

The CHAIRMAN. Another interesting statistic in L.A. is they are at one percent, I think the number was, vacancy rate. I mean, it is astronomical. There just isn't anything there to be rented out, and that is why this master plan, I think, is so critical. Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman. And Mr. Secretary, I would like to thank you and your team for the presentation today and all of the work that you have contributed to improving access to care for our veterans, and all the other responsibilities within your purview.

I want to, in addition, commend you for the focus on mental health access and treating veteran suicide like the crisis that it is, and meeting that crisis with a sense of urgency. So the \$7.8 billion to improve mental health access is certainly welcomed.

I would ask that in addition to your comments, that it be a standalone priority within the VA, much the way reducing veterans homelessness is a standalone priority, I think veteran suicide is just that serious, and we still are in a crisis. And I think articulating that from the very top that this is, in addition to overall access to better health care, physical and mental, reducing veteran suicide is a priority. I think the more we say that, the more we act on that, the more we follow through, the better outcomes, the fewer

deaths. This is wholly preventable, and I just, again want to thank you.

Secretary McDONALD. Congressman O'Rourke made a suggestion to us when we met and went through our 12 priorities for the year to call out vet suicide prevention. We had it there, but we did not have it called out as explicitly, and we have changed that. So we thought it was a good suggestion. We do listen, and we do look for your comments. So we do try to improve.

Mr. O'ROURKE. Thank you. I really appreciate that. On that same note, we know that access—I think we know, I certainly feel this way—that access to mental health is connected to successful suicide prevention and treatment for those who have suicidal ideation.

As you know, in El Paso, but throughout the country, we have critically underserved areas when it comes to mental health. To use El Paso as an example, we have the same mental health staffing today that we did in September of 2014, when we really became aware of how critical the crisis was in El Paso. And I know that Dr. Shulkin and Gail Graham, the interim director, Brian Olden, had a mental health in El Paso, are all doing amazing work, and yet it is not working.

And I want to know what we are going to do to elevate it beyond where you are today to recruit those providers to underserved communities like El Paso. Because I know that those providers will prevent suicides. They will save lives if we can get them in our communities. So what additional flexibility do you need to pay them more, to forgive more of their medical school debt, bonuses to retain them in place if they are performing according to the standards that we have set for them?

And what can we do to implement the very exciting proposal that Dr. Shulkin presented in October, which would have us leverage partnerships for what I would call non-VA core competencies, and elevate those conditions like PTSD and traumatic brain injury that are uniquely connected to combat and service?

So don't hire the podiatrist to know, you know—no offense to podiatrists and people with issues like that—but that can be seen in the community. I am sorry, Brad. But that psychiatrist, we are going to focus almost mono-maniacally on getting that psychiatrist into our medical centers to the exclusion of some other types of providers whose capacity is already represented in the community.

Secretary McDONALD. You know, I think, as we have worked together on our relationship with the local medical school in El Paso, to me, the top priority has got to be getting more residencies in there for mental health. There is just no question about that.

David and I have talked that as we put these residencies out, mental health, primary care have got to be some of our top priorities, and then making sure those people locate in the rural areas where we need them.

We are fortunate in a way that we don't have the issues that the private sector has with mental health where the CEO of Massachusetts General told me every mental health patient that walks in the door, he loses \$100. We don't have that. So we can get mental health professionals working for us. We need to have the

residencies and then need to work with the medical schools to create the throughput.

And then I think what we are going to need to do—we do have some flexibility on reimbursement of medical school debt, and we do have flexibility on incenting people locating in rural areas. But I think if we could make that even more, that would be helpful, and we will come back to you with specifics on that.

Mr. O'ROURKE. I would appreciate a specific request, a level to which you need flexibility to bring these much-needed providers in underserved communities.

Dr. SHULKIN. I also just want to thank you for your efforts. Through your efforts, we have worked with Texas Tech to be able to recruit additional psychiatrists into working in the VA.

Very important to work with the community. We can't—as you know, we have 116 openings in El Paso. We have only been able to fill 91; 21 percent vacancy rate. So we need to work with private partners.

I also want to thank you for your offer to go out and help us recruit. And I am going to take you up on that offer. We are going to go out and we are going to recruit together. But we need everybody's help to let people know that if you are a mental health professional, the VA needs you. We want you. There are jobs available. Please come and work with us.

Mr. ROE. Thank you, appreciate that. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Benishek, you are recognized.

Mr. BENISHEK. Thank you, Mr. Chairman. Well, good to see you all again. I got a couple things I want to touch on. One is a sort of a specific item that came up to me yesterday, frankly. I had the—oh, no, the third-party administrator—Health Net, their representative come in to talk to me yesterday. And I asked them, you know, what are some of the problems with implementing the access in the community?

And one of the surprising things that she, the representative, told me that a lot of the cases, they have a hard time discerning what the VA wants for a provider. And that is because, apparently, the person who is actually making the consultation writes a brief note like, I need a thoracic surgeon for a thoracic aortic aneurysm. But by the time the third-party administrator gets it, it is a 30-page thing that they have to get a professional in there to kind of read through the 30 pages.

Apparently, once the physician makes the request, some other bureaucrat gets hold of that request, adds a lot of the record to it, and they tell me that is a major delay in getting people to the right person.

So I do not know how much you are familiar with that, maybe Dr. Shulkin is. But can you just please address that to me and see what you can do to fix that problem?

Dr. SHULKIN. Yes. I think the process is very complex, and so we were meeting with the same person you probably were from Health Net the other night in the Secretary's office, and what we agree is, is that we need to be together doing this. And, in fact, we have started pilots throughout the country where we embed the staff from the DBA with the VA people, so it is not phone calls and faxes, but doing this together. So—

Mr. BENISHEK. Right. Well—

Dr. SHULKIN [continued]. You are correct.

Mr. BENISHEK. I just want to—that's one of the concerns I had with a third-party administrator is all of a sudden we got two bureaucracies now. We have the VA bureaucracy, and we have the third-party administrator bureaucracy. And this is a communication issue between the two of them. I don't know what the solution is, if it is better to have an outside bureaucracy, a private sector bureaucracy, or the VA bureaucracy. But having the two of them—

Secretary McDONALD. No. I think the solution is treat them as one, and then use Lean Six Sigma to go through and lean the process, so it becomes very linear. And that is what we are going to do.

Mr. BENISHEK. Well, that sounds pretty technical, and I don't understand what it—

Secretary McDONALD. It is what business people do every day.

Mr. BENISHEK [continued].—what it means. Let me just go into one more thing, and then I want to change the pitch a little bit. The Chairman mentioned in his opening comments about Mr. Gibson's frustration with a process that occurred, apparently, in Albany for a medical director that was attempted to be disciplined in some manner and then got thwarted by the courts. Can you kind of tell us more about that, because I want to be sure that you have the tools necessary to do the appropriate discipline. That is what we are talking about all the time.

So what went wrong there? What is the story? Is there something we need to do? Can you kind of go into that a little bit more? I am just not familiar enough with it.

Secretary McDONALD. The Chairman was talking about three particular instances, where Deputy Secretary Gibson, as the deciding authority, decided certain punishment as it pertains to three senior executive service employees. Those three appealed to the Merit System Protection Board. And in each of the three cases, the Merit System Protection Board—well, it is hard to generalize for the three, but basically in two of the cases, they said it looks like what he said was right, that they lacked judgment in what they did, but they vacated the punishment because we didn't punish more people than just them.

And what Deputy Secretary Gibson said, and we agree, is that it seemed less like the Merit System Protection Board judges didn't understand the intent of Congress or our intent, in punishing those employees. As a result of that, we had a discussion last night with the Chairman and the Ranking Member about an idea we had. It was actually Deputy Secretary Gibson's idea that we make all VA employees Title 38, so that—because we are like a business, we happen to be a—if we were a company, we would be a Fortune 6 company—treat everybody in VA as a Title 38 employee, which would give us more flexibility in terms of paying them competitively in the medical community, as well as giving us greater flexibility in disciplining them without all of the things that happen with the senior executive service.

So we have put that proposal forward. We have to do a lot more work on it. It is just preliminary. But we are going to work with the Chairman and the Ranking Member to do that.

The CHAIRMAN. Thank you, Mr. Secretary. And if I could, Mr. Secretary, a point of clarification, it is not all VA employees under Title 38, but the SES level. Because I—

Secretary McDONALD. I am sorry, yes, sir. You are right.

The CHAIRMAN [continued]. You just lit a fire that—

Secretary McDONALD. No, I did—Mr. Chairman, thank you for covering my back.

The CHAIRMAN [continued]. Anything I can do for you, Mr. Secretary. Ms. Kuster, you are recognized, and I apologize for missing you before.

Ms. KUSTER. That is all right. Thank you very much, Mr. Chair. And thank you to the team here today for presenting the budget in such a coherent way. We appreciate it. I just wanted to follow up on Mr. Takano's line of questions and just to give a shout out to Mr. Coffman and the Oversight and Investigation Subcommittee. We are going to be doing a regional hearing in New Hampshire on the 4th of March with the folks from White River Junction VA about the alternative remedies that they are using for to avoid—to bring down—the opiate prescriptions, and I think we will be introducing legislation on best practices and moving that across the VA.

And my hope would be that the VA, frankly, can be a leader nationally in bringing a bend in the curve on this opiate crisis. One of the things that we have learned in New Hampshire is that four out of five of our heroin addicts, where we have been particularly hard hit—400 deaths last year—started on prescription medications. So we are really focused on that generally.

But also four out of five have co-occurring mental health disorders. And so my questions, along with Congressman O'Rourke, are how we can bring more treatment, mental health treatment, in the VA to the rural areas. And maybe we could consider legislation not just for physicians, but for therapists to encourage them to come to rural areas by alleviating their school debt. So that is one issue.

The other issue, and just focusing in on these evidence-based alternative therapies, I know that one of the problems we have—and this goes to, actually, from the Affordable Care Act—using pain as a fifth vital sign and adds an indicator of quality.

Again, our bipartisan task force is working across the aisle. I am working with Representative Mooney from West Virginia on this. Is there anything in the VA where you are still using pain management as an indicator of quality that might be encouraging prescribers to use too much opiates, and can we help to turn that around? And would spreading these best practices help? And I will end there.

Secretary McDONALD. Let me deal with the rural area medical infrastructure first. We had an interagency task force meeting on rural poverty, and the President was there, Sylvia Burwell, who is the Secretary of HHS, Tom Vilsack, Secretary of Agriculture. And we had a long discussion about this medical infrastructure. I really do think there is a big opportunity to improve the medical infrastructure in rural areas.

I know as a former CEO, when I would decide to put a plant somewhere, you look for infrastructure. You look for roads. You

look for electricity. You look for water. You also look for medical care.

And so we had a discussion about this, and many of the ideas that we have talked about, I think are actionable for us, because VA trains 70 percent of the doctors in the country.

Ms. KUSTER. Right.

Secretary McDONALD. So we need the residency slots. Then we need to work with the schools to create the residency training, because obviously, it is difficult to create that kind of training program and frequency in a rural area, given its location. So this is a ripe area for us to work together, I think, to really help our country. Ask David on the opioids.

Dr. SHULKIN. Yeah, Congresswoman, I appreciate you bringing this attention again on this issue of opioid misuse and what we can do. VA has already begun to address this, but it has a lot more to do. As I said, we have 16,000 fewer veterans today taking opioids. We are using routine urine tox screens to identify people who are taking multiple drugs. Because you are correct about the comorbidities of mental illness.

We have started what is called academic detailing, which means that rather than going and talking to doctors about how to use drugs like the pharmaceutical industry, we actually try and teach about the appropriate use of drugs and how they can avoid and use alternatives to opioids.

So we do see VA as a national leader in this. We do think we need to do more. We are focused on this. We are looking forward to that hearing and seeing what else we can do.

Ms. KUSTER. Well, and just quickly, I am the co-chair of a bipartisan task force on ending the heroin epidemic, and we would love to work with you, maybe some kind of a national panel/symposium, on how we can use the lessons from the VA to help civilian-side prescribing habits, so. Thank you very much. I yield back.

The CHAIRMAN. Mr. Huelskamp, you are recognized.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the topic of consideration today. And Mr. Secretary, I appreciate the visit to my office yesterday, and I particularly was pleased by your continued commitment to work to make Veterans Choice permanent. And I think that is a critical item that we do need to pass.

And we discussed a number of things, and I would like first to ask Dr. Shulkin to follow up on one thing we talked about that—you know, I have 70 community hospitals and about 1,000 other providers now in the network for Choice. You have announcement, I guess, of a way we can reduce the paperwork and simplify some of that process for our providers?

Dr. SHULKIN. In terms of getting them paid?

Mr. HUELSKAMP. Yes, and some—

Dr. SHULKIN. Yes, yes.

Mr. HUELSKAMP [continued].—of the paperwork mandates that you had when you first implemented Choice.

Dr. SHULKIN. Right. Yes. Having spent my life trying to get paid for managed care companies, I am very sensitive to this. I believe that if you treat our veterans, you deserve to get paid and paid timely.

So we are—the major thing that we can do—and we will do this in the next two to three weeks—is—we will de-couple the requirement to submit all the medical records in order to get paid.

So, in other words, if you have a authorized claim, or an authorized claim that has been submitted to us, we will pay you and not require that you have to give us all of the medical records first. That will bring our payment rates up by almost 20 percent above where they are now.

Mr. HUELSKAMP. And that will be implemented when?

Dr. SHULKIN. We are waiting for final contracting approval with VA, we hope within two weeks.

Mr. HUELSKAMP. All right.

Secretary McDONALD. That is the best practice in the private sector.

Mr. HUELSKAMP. Absolutely. And I appreciate that. Again, I have a lot of providers, 70 community hospitals, and they want to help. And they also would like to get paid, and they also would like to cut through the paperwork. So I appreciate that.

The other question is—I would like to mention that I know Mr. Pummill had mentioned, I think it was at a hearing late last year, he said it was almost impossible to discipline most VA employees. And Mr. Secretary, do you agree with that statement, and if not, why?

Secretary McDONALD. I wasn't at the hearing, so I think the solution that we have talked about for SES employees is, for me, the, you know, the answer to the question. We have terminated about 2,600 employees. That does include the expiring of probationary periods. We have 20 employees from ten locations that have been disciplined for scheduling errors.

So, I guess, I would not agree with your statement, Danny. I don't know the context of it. But I would like to move forward on exploring what we need to do to get our discipline for SES employees effected.

Mr. HUELSKAMP. So, Mr. Pummill, could you explain—expand on that? And do you think the proposed legislative change would fix the issue? We do have—I believe we do have a problem.

Mr. PUMMILL. I still stand by my statement that I made last time. I made it in the context that it is too hard. It takes a lot of time, a lot of effort, a lot of money. Time, effort, and money that should be used taking care of veterans to follow rigid rules and procedures and policies.

I do think what the Secretary has proposed with the Title 38 with the SES would go a long way, not just to helping us hire better people, but with the long-term disciplining of people out there. That is a good start. But I also agree with the Secretary that we have got to concentrate on this budget and move forward and get going on stuff.

Mr. HUELSKAMP. Absolutely. And the Secretary and I talked about the VA Accountability Act, and there are some provisions in there definitely would help that, if the Senate would move forward, and the Administration could be supportive of that.

And one of the things we talked about in the last month in the Committee is, when I discovered—maybe the rest of the Committee—about the individuals in Phoenix were on 600 days of paid

leave. I thought we were going to fix that situation. Their paid leave is over, but they are now working for the VA again. And if we can't fix that situation, can you explain, Mr. Secretary, of how folks that I think we all agreed would not be working for the VA. You know, 600 paid days and at the end of the day, are still working at the VA and other—

Secretary MCDONALD. Yes, sir. Well, you recall in the testimony Sloane Gibson gave, Deputy Secretary, he said that we were going to change our policy. That the policy of waiting for the IG investigation to be over was taking us much too long. So we are now doing our own investigations and bringing charges much more quickly.

In the case of those individuals in Phoenix, we expect within the next couple of weeks, you will be hearing something about that. We are wrapping that up.

Mr. HUELSKAMP. And that—those were the folks that were on paid leave. Are the other two folks that—are these the ones that targeted the whistleblowers?

Secretary MCDONALD. There were two people in question who were on administrative leave. We have brought them back to work. In fact, immediately after that hearing, we brought them back to work, and they are now working in the VISN headquarters. And there is a third individual that was part of the investigation who is currently working within the facility.

Mr. HUELSKAMP. Thank you, Mr. Chairman, I yield back.

The CHAIRMAN. Mr. Walz, you are recognized.

Mr. WALZ. Thank you, Chairman. Mr. Secretary, thank you to you and your team, for the work you do and we are just—I know it is early here and we are still parsing through the budget, but we all know budgets are more than just finances; it is a moral document that reflects our values. And so when you bring these issues to us, we are trying to find, and each of us is pulling out, things that are important, are important to our veterans. And I know that I do not want to over-simplify, but that is exactly what I will do. But this issue keeps coming back on, on opiate addiction and some of those, and it ties in closely to the issue Mr. O'Rourke and Ms. Kuster talked about that they are all interconnected on mental health piece on suicides and things.

I think you heard, and I point this out, one of the root causes of opiate and opiate addiction is pain as the systemic cause. And I bring this up because you are hearing this—and I am going to reflect a little frustration, that we are always seeing someone as being reactive. Here, we were proactive. Eight years ago, the best minds out in the private sector dealing with pain management put together and passed, we did it here, the VA Pain Management Care Act. And it was meant to be the best practices step tiered, and it was all aimed at treating the pain and reducing—because I think just showing opiate numbers, sometimes people need that. And I think just showing a reduction, I have got people calling my office who there is nothing in between. They are off and on. So it is more complex than that. And we put this thing into place, and a year ago, I guess it was not quite a year, in June last year, Dr. Clancy testified, it was never fully implemented. And it expired and was not reauthorized. And I asked at that time to get a full

accounting of that because it was already three months before that I had asked. I have never received an answer. This was a bill that Congress passed proactively, addressing what smart people outside of there and in here crafted together to prevent this very thing we are seeing now. And so I come—I know you are doing it. I know that was a different world, that was not you, that was not your admin—I point it out though, because I think at the risk of the frustration of the American people, we want to fully fund what you need to do this.

And this Congress passed and funded the Vet Pain Management Act that people out there still believe is the best way to reduce opium addiction. Never implemented, no answer why, expired, business as usual.

Secretary MCDONALD. We'll get you that accounting back, that reconciliation back. It is my sense, Congressman Walz, that many of the things that were in that bill we are implementing.

Mr. WALZ. I think you are too. I believe that.

Secretary MCDONALD. But we owe you an accounting back as to what we are doing and what we are not doing and why, but my sense is—we are doing a lot of that.

Mr. WALZ. I think that—

Secretary MCDONALD. These were all good best practices.

Mr. WALZ [continued]. Yeah, I think so. And my guess is you are exactly right. I think it is probably happening. But there is a disconnect between that, the private sector pain management experts, and this goes into device manufacturers that are coming up with things to block this. I mean, you know more about this, Dr. Shulkin, than I do. These folks come to me and the disconnect back here to Congress and then I think some of us who have been here, we are going to see well-meaning members who come here, and they are going to tackle an issue that we have already tackled once, or we have done it again, and then that is that reinventing the wheel that, in a budget, I do not want to see any of those resources not go to exactly what you need them for. So I certainly do not want to say that they were not being enacted.

Secretary MCDONALD. The only thing I would add to that is in the different conferences I have spoke at, and the different medical schools where I have spoken, there's a clear need of the faculty to do a better job teaching pain management. There just has not been enough training in medical school—

Mr. WALZ. That is right.

Secretary MCDONALD [continued].—in pain management.

Mr. WALZ. And private sector.

Secretary MCDONALD. We are trying to go upstream and get some of these things dealt with strategically rather than just the what happens now—

Mr. WALZ. We treat addiction after it is there, good luck.

Secretary MCDONALD. Right.

Mr. WALZ. We all know what that goes. We know recidivism rates. We know everything else and all of the heartache and the destruction of lives that go with it. That is why this was implemented to track these people through from the very beginning with a case manager on pain and that. And so if you would take a look at that, I would appreciate it. I think we would come back—and

I know you're doing this, I know there is experts in this, but I am hearing it from the outside that we have really missed an opportunity to get on the front end. And maybe I will segue into that implementation the Clay Hunt Act. I know you talked about it at the conference, I know it is real, I think Mr. O'Rourke is pointing out what is right. I know in this case that the commitment from the VA is there to get this on the forefront. I do think it is important to keep mentioning that, that it is a priority. It is out there. We are implementing. And we are going to see what happens with that. I will leave with my last comment on this and this is just, I guess, the Agent Orange Act expired. I am not convinced all the research is in yet, but it is what it is. You still have the ability on presumptions. Where does that fall into this because we know what happens. When something is added on this, it all ties together with case backlogs, Nemer (?) and everything else, so—

Secretary McDONALD. One of the things I have tried to do as secretary in my twenty-some months so far is to look at a lot of these things that have lingered for some period of time. The Chairman was kind to mention the five-year-old lawsuit we had in Los Angeles that was paralyzing our ability to do things on our campus there—our 388-acre campus there. So I have taken a look at a number of these things. C-123 Agent Orange, reservists literally scraping out the residue of Agent Orange from these airplanes. And I have put in place a more liberal interpretation which gets those veterans the presumptive cares that they need.

I have done the same thing with the presumptions around Camp Lejeune, where we have included eight presumptions for Marines at Camp Lejeune. I just took a look at Bluewater Navy, I went back through the Institute of Medicine study. I also went through the Australian study, and it was my point of view that the science does not exist yet to do a presumptive for Bluewater Navy.

Mr. WALZ. My time is going to be up, Mr. Secretary, and I want to thank you for all those that might—I guess, maybe do you need the Act to further the science? See that is my fear, that the Act—

Secretary McDONALD. No, I do not think so. In fact, what we did with the Bluewater Navy is, we didn't want to just say no, so what we have done is we have formed groups there to go out and do the research to discover whether or not we should create presumptions for Bluewater Navy.

Mr. WALZ. And I am grateful for that. I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Mr. Walz ate up one minute of your time, Mr. Coffman. So you are recognized five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman. And Mr. Secretary, thank you so much for stopping by my office yesterday to brief me personally on the budget. Congressman Lamborn asked about the IG report on Colorado Springs and asked the status of the manager that was removed. And there was not an answer given to that, so let me follow up with that. What is the status of the manager that was removed?

Dr. SHULKIN. Congressman, my understanding is, as the Secretary had said earlier, that we have replaced the supervisor who

was responsible for the scheduling. That person went to work in another part of the facility.

Mr. COFFMAN. What disciplinary action did they receive?

Dr. SHULKIN. I am not aware that there was a specific disciplinary action for that individual.

Mr. COFFMAN. Mr. Secretary, don't you think that is a problem?

Secretary McDONALD. Not the way I read the IG report, Congressman. I think if you look at the IG report, the IG report does not call out anyone for malfeasance. What it does indicate is, number one, we didn't train the people properly.

Mr. COFFMAN. Who was responsible for that?

Secretary McDONALD. Well, the leader is always responsible.

Mr. COFFMAN. Well, then why weren't they held accountable?

Secretary McDONALD. Well, they are held accountable. They are held accountable on their performance review, that doesn't necessarily mean they get fired.

Mr. COFFMAN. Or disci—

Secretary McDONALD. Firing doesn't lead to—

Mr. COFFMAN [continued]. Or disciplined.

Secretary McDONALD [continued].—excellence in an

Mr. COFFMAN [continued]. Or disciplined.

Secretary McDONALD [continued].—organization.

Well, discipline occurs on many different levels. I mean—

Mr. COFFMAN. Well, I would like to know specifically what discipline is.

Secretary McDONALD. Well, we will get back to you. We will get back to you on how it was handled.

Mr. COFFMAN. Thank you. When you mentioned Title 38 on the SES, what percent of the workforce would that apply to?

Secretary McDONALD. Well, SES is about 540 or so individuals of a total of about 360,000.

Mr. COFFMAN. So what about—

Secretary McDONALD. They are the senior leaders of the organization.

Mr. COFFMAN. And what reforms are you putting forward, best professional judgment, given the fact that you came from the private sector, what personnel reforms are you putting in for the others, for the rank and file?

Secretary McDONALD. Yeah. Right now, as I told you, we are training the organization in mission and values and leadership. We have taken over 12,000 people and trained them. These training sessions are cascading throughout the organization.

Mr. COFFMAN. So there are no reforms in terms of—

Secretary McDONALD. I have not had—

Mr. COFFMAN [continued].—making it easier to let poor performers go? You are not putting any reforms in that direction?

Secretary McDONALD. We have let 2,600 people go.

Mr. COFFMAN. Okay. We had, I think it was, House Resolution 280, that came before the Congress. And we had testimony from your staff that you were neutral on that. Let me explain what that does. One of the biggest scandals the VA has had is on the appointment wait times. And I think that that corruption was fed through bonus money, was fueled through bonus money to bring those down. And yet, we have had legislation before us that your office

is neutral on, that says that you ought to have the ability to claw back bonuses when they are fraudulently given. The only way that you can currently claw back bonuses under existing law is if it is administratively given to the wrong person, and for no other reason. Why would you be neutral on such a simple reform like that?

Secretary McDONALD. Well, bonus spending across the VA is down, and down dramatically. In 2015—

Mr. COFFMAN. That's not the—

Secretary McDONALD [continued].—total VA spending for all the work categories—

Mr. COFFMAN. Sure. But why would you—somebody who fraudulently received a bonus, why would you not demand that the taxpayers and the veterans get that back?

Secretary McDONALD. A reduction of \$19 million, it was 7 percent below the previous year. And here's a graph that shows you the reduction in bonus spending. And as I have laid out for the Chairman a couple of times, we are—

Mr. COFFMAN. So you are okay. Let me get this straight. You are okay with somebody who has got a bonus, even though it has been proven that they should have never got that bonus because their conduct, that was fraudulent in receiving that bonus, like under the appointment wait times. So what you are saying by not supporting that legislation is you are okay with that.

Secretary McDONALD. I'm working on the future, not the past.

Mr. COFFMAN. Well, you are, how?

Secretary McDONALD. The future is about making sure people are given performance awards that measure what they do, and that is why we are bringing the bonus totals down for the department. And that is why we are putting the—we are relatively rating people consistent with the best practices in the private sector.

Mr. COFFMAN. We had Glenn Haggstrom who—a billion dollars over budget in the Aurora VA Hospital, retired just right before he was supposed to be interviewed by the IAB. We just had Dr. Schinazi retire just before—just after the story broke about the hep C problem where he was a researcher with VA, helped develop the drug there. And then took that intellectual property, created a private entity, where VA did business with that private entity. And he retired. I mean, what is going on? Here is the problem, that you are saying great things here, but you are not attacking the heart of the problem, and the heart of the problem is—we have a horrible personnel system that allows this bureaucrat incompetence, that allows this corruption to continue. Where are you on this?

Secretary McDONALD. Congressman Coffman, as I said earlier, I think if we can work on the reclassifying the SES, this Title 38, that would be a big step forward. And, you know, as we have said previously, you can't fire your way to excellence. And it is my experience that we are taking—

Mr. COFFMAN. Well, that would be a good start.

Secretary McDONALD [continued].—the right steps, we are taking the right steps—

Mr. COFFMAN. It might be a good start.

Mr. McDONALD [continued].—to create a high performance organization.

Mr. COFFMAN. I think firing incompetent people would be a good start.

Secretary McDONALD. And by the way, I don't think I have the authority to claw back somebody's bonus after they retire. If you want that, you will have to change the law. I don't write the laws.

Mr. COFFMAN. Could port (?) the law and we have legislation—
Secretary McDONALD. I don't write the laws.

The CHAIRMAN. Thank you very much. And also to bring all the members up to speed, we are working with the four corners on trying to pre-conference and negotiate a lot of these issues. Both sides are working collectively. The language that you referred to has passed the House. We are trying to get our Senate colleagues to follow us so that we can in fact change the law, so that for those who have broken the law in particular and have been convicted, to give you the ability, or your successor, to go in and claw that bonus back. I think that is an important tool that we should focus on. You don't have that ability now. We found that out after Pittsburgh. I think—was the Legionnaire's issue there. Mr. McNerney?

Mr. MCNERNEY. I thank the Chairman, and I thank you, Mr. Secretary and your staff for your hard work on developing this budget. I have some probe go (?) questions, if you don't mind. The Palo Alto VA is in my—it is not in my district, but a lot of my veterans use that. And they provide excellent service, no doubt about it. But it is in a very high-priced area. It is very expensive to live in Palo Alto. And the commute there is murder. Do you have any way to compensate for high cost areas for your employees? Because they are going to be, you know, priced out of that office.

Secretary McDONALD. We do have some flexibility, sir, for location premiums. I would argue it is not enough. And if we can do what we talked about with Title 38 that would give us more flexibility. The Palo Alto facility is one of our very best. Many of the doctors there also teach at Stanford Medical School, and we do a lot of research there. It is really an outstanding facility. It is probably one of our best Lean Six Sigma facilities in the country.

Mr. MCNERNEY. I agree. Moving on. The VA has a construction backlog that can last years. Of course, we have experienced that in my district on the French Camp facility. Are you in support of public-private partnerships or partnerships with local governments where the state, for example, can pay part of the construction fees and partner with the VA or the Corps of Engineers?

Secretary McDONALD. We have done that in the past and that is one of the reasons we are looking for the extended use leasing on the Los Angeles campus.

Mr. MCNERNEY. Have you found that to be a successful model?

Secretary McDONALD. Yes, in fact at Menlo Park, which is very close to the Palo Alto campus, we have an extended use lease going with a company called CoreRVA who built a building for aged veterans, aging veterans, and we are leasing that building back from them, or renting that building back from them.

Mr. MCNERNEY. The last question has to do with the way veterans use VA benefits. Do you track demographic data like gender or ethnic group or economic class, in terms of how the benefits are distributed?

Mr. PUMMILL. We have pretty extensive data, location, whether or not they are married, the age of the veteran. I'm not sure if we track economic, but everything else we pretty much have.

Mr. MCNERNEY. Could that be made available to my office, that information?

Mr. PUMMILL. Sure. We actually put out a book every year by state with all that data. We can make sure you get a copy.

Mr. MCNERNEY. Okay. I mean, the plan that you put forth is ambitious. It is good. The VA needs to modernize, and I think everyone on the Committee here is behind this effort. There is going to be some disagreements, but my hat is off to your efforts and we are going to try and support you the best we can. Mr. Chairman.

The CHAIRMAN. Ms. Walorski, you are recognized.

Ms. WALORSKI. Thank you, Mr. Chairman, and thank you, Mr. Secretary, for being here today and bringing your team. And I just wanted to say how thrilled I am to hear that you have made the transition to the concept of running on principle and not just necessarily on the bureaucratic rules in the VA because there are so many. I look forward to that as it kind of winds out in my district.

Ms. Council, not to leave you out, I have been interested in this issue with IT since I have been here in Congress. And I am just curious, you are asking for—the VA is requesting \$4.2 billion for cutting-edge information technology. I have heard that probably three times since I've been here, the additional billions of dollars that have to go into this new cutting-edge technology. My first question is just quickly how much of that money is going to be kept for just maintaining the legacy systems we have, and then, how much of that is actually being carved out for new cutting-edge technology?

Ms. COUNCIL. I don't have the breakdown, but I will get that to you. What I will tell you is we have a large legacy issue that we need to address. We are increasing our spend on security to \$370 million, fully funding and fully resourcing our security capability. In addition, we are putting in well over \$50 million in creating a data management backbone that we didn't have and we have added five new functions within the organization that will modernize the IT organization.

Ms. WALORSKI. Let me ask you this just quickly. So is this money you're requesting, this \$4.28 billion, is this going to take care then of the maintenance of the legacy system and achieve the goals that you are talking about right now, or are we going to be looking next year at another 5 billion, another 6 billion? Is this take care of and suffice to get the VA where you need to per the goals that you just talked about?

Ms. COUNCIL. Yes, it does.

Ms. WALORSKI. Okay. I appreciate that.

And, Secretary McDonald, I just wanted to again bring you up to speed with what is happening in the state of Indiana, and I am again asking that you come and visit our northern Indiana VISN.

You know, two of the things that continued to be an issue, and for as fast as you are working to reform these things, and for the footsteps that we are taking forward on reform, and we are, and I appreciate that. You know, we still deal with an issue in our district, it is probably not unlike anybody else in this country, but it

really makes a difference in our district, is that all of our top-level VISN executives have been promoted around the country and now we are just not dealing with doctor shortages and nursing shortages, now we are dealing with administrative shortages. So when a veteran exhausts all, you know, appeals and those processes, they come to the Congressional office and they say will you help? And they are at the end of their end. And now, as we have to get involved, and now with Congressional inquiries and battling for the sake of our veterans and trying to bring those mountains down, we are going through temporary people that really aren't really accountable to anybody, and it really provides zero transparency then as we tried to come and in good faith with the VA, try to figure out where some of these mishaps are.

And I just want to give you the one example, because I am going to need your help on this situation, is, I have got a veteran that was in the appeals process for years, and it has been back and forth, where the VA will say no, they will deny him, and then they will come back and they will prove some point, and they will say yes, they will say no, and they will say yes. This guy, in bad, bad health, with serious heart complications and surgeries, is left holding a bag that now the VA says yes, we're going to pay the bill. And the hospitals are coming back to him with interest. Over the last four years, I have got a veteran right now responsible for \$10,000 of interest and this was never his fault. But I look at part of that of saying can you help us mitigate that with the VA, number one. Number two, how long can we possibly and can the VA possibly run with temporary administrators?

Secretary McDONALD. If you could, Congresswoman, please get me his name.

Ms. WALORSKI. I will.

Secretary McDONALD. And I will work on that. We have the ability to give relief on that—if we made a mistake—to give relief, financial relief on that interest that he would be charged. So on all these things, if a veteran comes to you, give him my phone number, give him my email address, you don't need to deal with it, we will. And we will get it effectively resolved.

The issue you mention on vacancies is one of the biggest issues we face, if not the biggest issue we face. It is ironic that when I talk to our organization, I do that a lot, because whenever I go anywhere I do town hall meeting, they tell me that people don't want to join VA because it is a maligned organization and everybody is being fired. And then I come and sit in front of you and you tell me nobody is being fired. And the truth, of course, is somewhere in the middle.

And our applications are down over 75 percent for available positions, and that's just unacceptable. It is a great place to work, and I have encouraged each and every one of you, and the Chairman has done it, and the Ranking Member, to go recruiting with me. And let's stand together and recruit the future leaders of this organization.

Ms. WALORSKI. Just curious, does this budget reflect any kind of new recruitment efforts or the tools that you need to do that?

Secretary McDONALD. Absolutely.

Ms. WALORSKI. Okay. I appreciate that. And I yield back, Mr. Chairman, thank you.

The CHAIRMAN. Dr. Abraham, you're recognized.

Mr. ABRAHAM. Thank you, Mr. Chairman and thank the Members for being here. Mr. Walz brought up something I think that is so important and that is the moral duty and the ethical duty that we as a Committee and you as the VA have for our veterans to ensure that the money that we give you is spent in the best fashion so that as many veterans as possible can get the best care. And I know you agree with that statement.

Certainly, it goes also to the trust issue. As a physician, I will write a prescription, I give a diagnosis, that patient trusts me. If I make the wrong decision, that patient could very easily die. And in your arena too, the decisions that you all make certainly deal with life and death on almost a daily basis such as any physician. And it brings me to the question I am going to ask you, Mr. Secretary, let's go back to this IG report that we keep going back and forth here.

Last month the IG testified that due to data manipulation, that the VA's backlog statistics were not reliable. And my question is how can we trust the Department's current figures when it comes to the request to fund 300 additional non-rating claims processors, 900 additional board of appeal staff, so where is that trust that we as a Committee and the veterans—how can you ensure that?

Secretary MCDONALD. Our data and our data integrity is absolutely critical to our success as it is to any business. So obviously, it is something we are working very hard on. I did not read that IG report as conclusively as you did, that—because it sounded from what you said as if all of our data was not good.

Mr. ABRAHAM. I am just ponying on what the IG said.

Mr. PUMMILL. Can I just chime in a little bit on this because, Congressman, I have read the report. I absolutely disagree with the IG's statement that the—

Mr. ABRAHAM. Well, let me interrupt. I mean, he is an expert in his field.

Mr. PUMMILL. I don't believe he is or he wouldn't have said that.

Mr. ABRAHAM. Well, then there—

Mr. PUMMILL. If you look at the statistics.

Mr. ABRAHAM [continued].—is a big divide there then I would argue that if we have got an inspector general of the VA's department saying one thing, you guys saying something else, where is the trust that that veteran—where is he going to find who to trust?

Mr. PUMMILL. The bottom line, Congressman, is last year we paid out more money to more veterans faster than we ever have in the history of the VA. All those stats are there, all that data is there. 1.4 million veterans, over \$90 billion in benefits and services. I mean huge numbers out there, and we are doing more and more and more and we are doing it faster and faster to veterans, so I disagree with your assessment.

Mr. ABRAHAM. You are reading the same report I am sure I am, the transcript of the IG report.

Mr. PUMMILL. Yes, I am. Absolutely.

Secretary MCDONALD. Believe me, sir, we read the reports. We read the reports.

Mr. ABRAHAM. I just have.

Secretary McDONALD. As you know, we don't have an IG right now.

Mr. ABRAHAM. I understand that.

Secretary McDONALD. And we have nominated, the President has nominated, a very talented individual that we are trying to get confirmed by the Senate. And I think what you will see is the quality of our work will go up.

Mr. ABRAHAM. You know, as a guy that deals in the objective, I just have a hard time understanding how there can just be spaces of worlds apart between your opinion and the IG's when you have data that is just in black and white. And we will continue to debate.

I want to get another question. Let me get another question in, Mr. Secretary. The Department's budget proposals put forth is about the simplified appeals process that would consist of closing records on appeals and eliminating what are termed optional hearings. And I guess what I'm asking, please provide details about the proposal including how it will strike—and it is a delicate balance, I realize, of achieving timely, accurate, and fair appeal decisions for veterans and their families.

Secretary McDONALD. As we said, Congressman, the proposal we put forward is a strawman. If you have better ideas, we would love to hear them.

Mr. ABRAHAM. We will get—

Secretary McDONALD. And as veterans service organizations have better ideas, we would love to hear them.

Mr. ABRAHAM. Okay.

Secretary McDONALD. What we all know is today is untenable, it is unacceptable.

Mr. ABRAHAM. I agree and I will certainly.

Secretary McDONALD. And what we are committing to with this proposal is, as we said, in the future 90 percent of appeals done in one year. So let's work together, let's get this done. And we are open to any idea, just like Congressman O'Rourke gave us an idea last week and we changed.

Mr. ABRAHAM. Just real quick, that 440,000 that are in the cycle now, is there just a guesstimate or an educated guesstimate, how many of those are within the two or three year processed appeal?

Secretary McDONALD. I will have to get back to you, sir.

Mr. ABRAHAM. That is all right. Fair enough.

Secretary McDONALD. I don't know the answer to that.

Mr. ABRAHAM. Fair enough. Thank you, Mr. Chairman.

Secretary McDONALD. Given that two percent of the people create roughly half the appeals, I would assume that there's quite a few that this is their, you know, multiple, multiple appeal.

Mr. ABRAHAM. So maybe past the three year.

Secretary McDONALD. Yeah.

Mr. ABRAHAM. Okay. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Mr. Takano, do you have a closing question please?

Mr. TAKANO. Mr. Secretary, I really want to get an answer on your planning for more graduate school education, more GMEs. And is your resourcing that you are asking for, is it adequate for

what we need in the future? I mean, we did insert 1500 more GMEs in the Choice Act, but the medical associations were all telling us they need more. And I am of the mind that this is perhaps the best area, the best Committee, to be able to try to make some headway into the overall doctor supply. And what you are doing to consolidate care in the community, I think, might enable us to have this be a platform.

Dr. SHULKIN. Congressman, first of all, thank you to the Congress for giving us the 1500 slots. The country needs them. We need more graduate medical education slots. And VA can really help in this. But of the 1500 slots, we have only used 372 today. And what we have learned is, is that we actually can't do everything that VA needs to do because we need the hospitals—we work with affiliate hospitals—they don't have the infrastructure and they don't have the ability to pay for these. So we would like to work with you and members of the doctors caucus, or anybody else who would like to, to give us the flexibility to help actually expand these medical education programs further. We would like to focus in primary care and mental health and in rural areas, absolutely. But we do need some additional flexibility to actually carry out the intent of Congress here.

Mr. TAKANO. Well, I hope that—I mean, I appreciate your working with Dr. Roe in the doctors caucus, but there are other of us who, Ms. Titus, myself, and Mr. O'Rourke actually were coauthors of that language that got into the Choice Act. We would be happy to work with you on that. I mean, the primary care doctors in mental health are exactly what a lot of regions need, rural regions, and suburban urbanized regions such as mine, we are under-doctored. And so we definitely want to work with you on these issues.

Dr. SHULKIN. Okay. Thank you.

Mr. TAKANO. Thank you.

The CHAIRMAN. Real quickly, Mr. Secretary, we talked about where the budget expands and spends more money, invests more in veteran programs, could you give us two or three examples of where this budget goes in and actually cuts some wasteful spending and programs? Not efficiencies, I'm talking about eliminates from the program.

Secretary McDONALD. Go ahead.

Dr. SHULKIN. Two areas where we have significant decreases as you know are in construction. We have actually taken our budget down significantly until we get the commission on care findings.

The CHAIRMAN. That doesn't count. Try again.

Dr. SHULKIN. No? Okay. How about this one then? We have actually reduced our funding for our EMR this year until we, Ms. Council and I, and the Secretary and others, get a clear plan on where we want to go with our electronic medical records.

The CHAIRMAN. No, my question was wasteful spending. And I don't think you would say the electronic medical record is wasteful spending. We are talking about a, now, \$180 billion budget. Is there anything that was eliminated this year?

Secretary McDONALD. Well we'd like to close those, you know, 10 million square feet of unused space. We have more space being created because we are saving about 5,000 tons of paper a year in VBA.

The other thing I will tell you is—we are only at the beginning of this. As part of our training program, this Leaders Developing Leaders, we have put in place a process called RAMP, which stands for Reports, Meetings, Priorities, and so forth, where groups of people get together and actually stop work that they are doing. We haven't put dollar amounts against all of that yet. We are cataloguing all the things we are stopping doing. And then, we will put dollar amounts against it, and we will come back to you and tell you what those dollar amounts are.

Remember in this budget too, one of the things we are proposing, if you will help us, is the creation of a unified holistic supply chain for VHA. There is a lot of money sitting on the table. We are committing here to saving at least \$150 million, if you can help us do that. Right now, each one of our facilities has its own supply chain. We know by consolidating those supply chains, we can save a lot of money.

The CHAIRMAN. And I appreciate that, and I do think you need to be looking for efficiencies, and I know that is something that you are focused on.

Secretary McDONALD. It is in our written testimony, if you—

The CHAIRMAN. But surely somewhere in a \$170 billion budget, there is waste that could be eliminated. If you would have some folks go out searching. We need to go ahead and adjourn now, but if you would, for the record, we will take that in.

Obviously, we are all trying to absorb as much of the budget as we can. So as we look through it, there will be more questions that this Committee will have. And I would, as our custom, say that all Members who have five legislative days with which to revise and extend or add extraneous materials to their remarks

Without objection, so ordered. And with that, this hearing is adjourned.

[Whereupon, at 12:00 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Corrine Brown

- Thank you, Mr. Chairman.
- Mr. Secretary, I want to thank you, and thank the President. During the President's tenure, discretionary spending has increased 86%. The President is doing his part to take care of veterans. I believe that this budget provides us with a starting point to begin the process of making sure veterans are getting the benefits and services we have promised them.
- I look forward to discussing your proposal to establish an additional appropriations account focused on community care, especially in light of your repeated requests for "budget flexibility."
- I want to be assured that this account will not take our focus away from providing the VA with the resources it needs to provide health care to our veterans.
- In light of the shortfalls VA faced last year, and the uncertainty of reform efforts, I want to ask you, Mr. Secretary, the question I ask every year - does this budget give you what you need to accomplish your mission?
- Do you believe that there are areas that need a special focus and may need additional dollars?
- I stand ready to do whatever I can to make sure you have what you need. But while I will be in the front line of fighting for the dollars you need, I want to be very clear - I expect you to spend every dollar we give you wisely for our veterans.
- I believe we must focus on our veterans. By focusing on our veterans we will begin the process of rethinking how we ensure that we keep our promises to them in the years ahead.
- So let us know what you need, and we will, working together, on both sides of the aisle, make sure you have the tools and the dollars to accomplish your mission.
- I yield back the balance of my time.

Prepared Statement of Robert A McDonald

Good morning, Chairman Miller, Ranking Member Brown, and Distinguished Members of the House Veterans' Affairs Committee. 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 this 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.

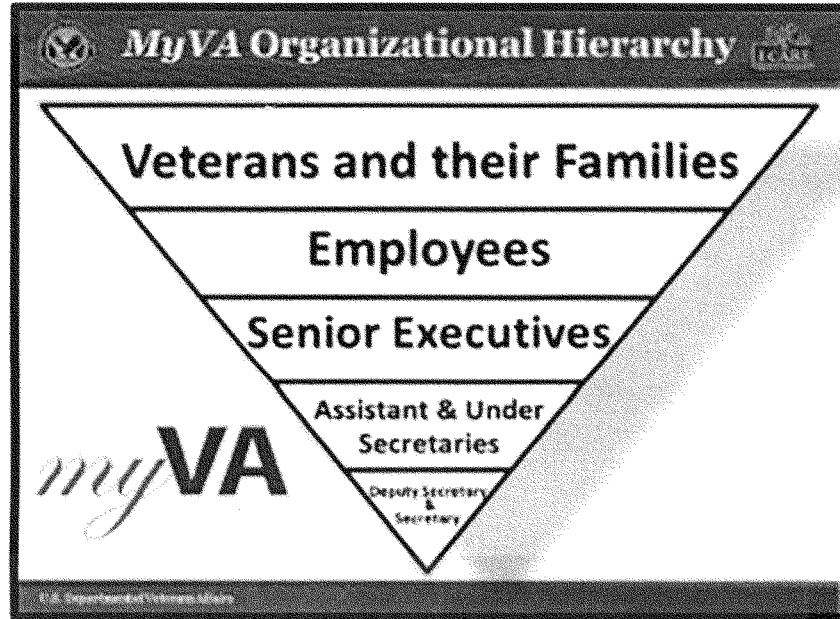
Effective change often requires new leadership, and we have made broad changes. Of our top 16 executives, 10 are new to their positions since I became Secretary. Our team today includes extensive executive expertise from the private sector: a former banking industry Chief Financial Officer and President 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 Web site that will replace numerous other Web sites and Web site logins with a single, easy to navigate location. The Web site 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 36 Community Veterans Engagement Boards, a national network designed to leverage all community assets, not just VA assets, to meet local Veteran needs. Fifteen 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 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.

Access. 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 backup, 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 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 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 Access Stand Down on November 14th-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 Level One, stat, consults that were 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 is continuing to maximize accessibility to outpatient services with the coming February 27th, 2016 Access Stand Down. The February Stand Down is 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 [476,672] 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. 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 2.2 million square feet in FY 2015, adding to 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. 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 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 who were entitled for 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; 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.

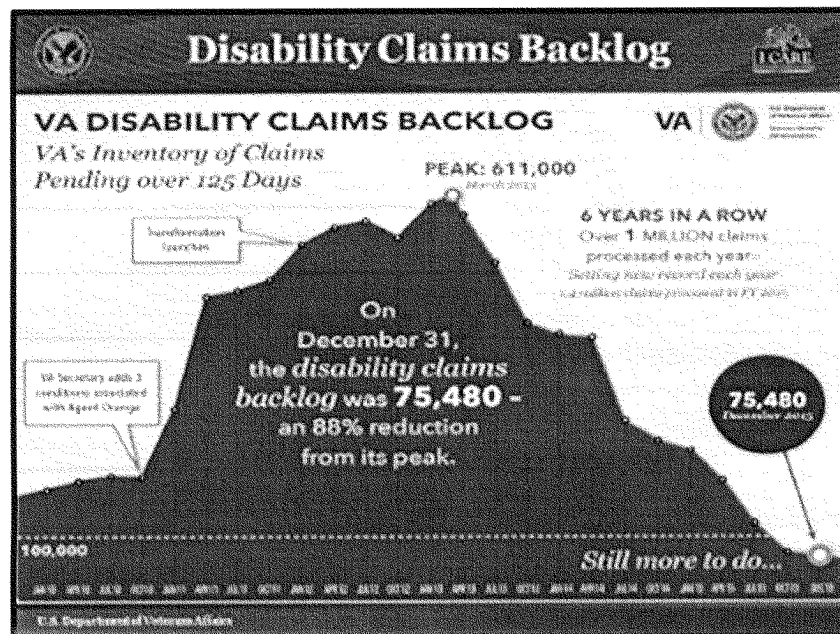
Directly related is Veteran unemployment, which dropped to its lowest point since April 2008, according to the Bureau of Labor Statistics' October 2015 report.

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.

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, analytic 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 transformation to MyVA 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 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 ad-

vance 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 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.

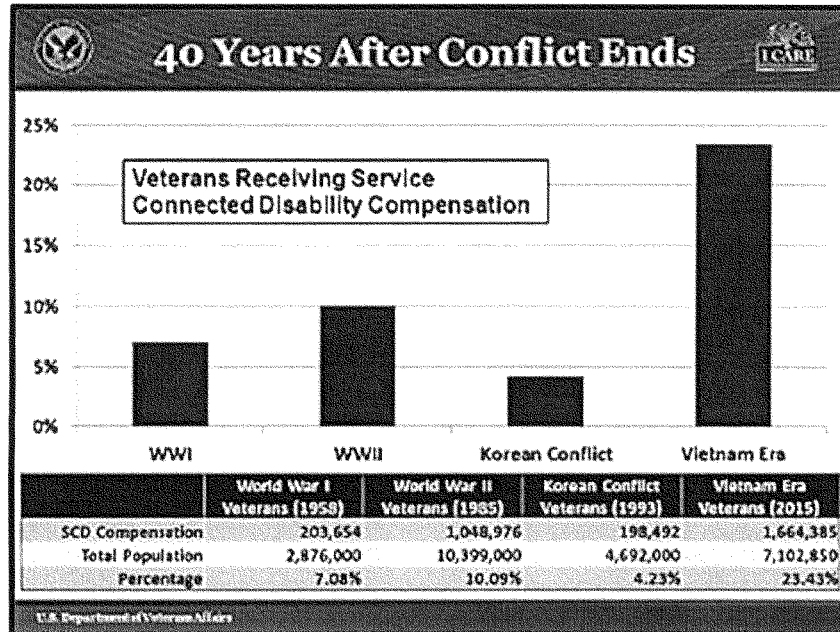
Rising Demand for VA Care and Benefits

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 health care transformation efforts and addressing that challenge.

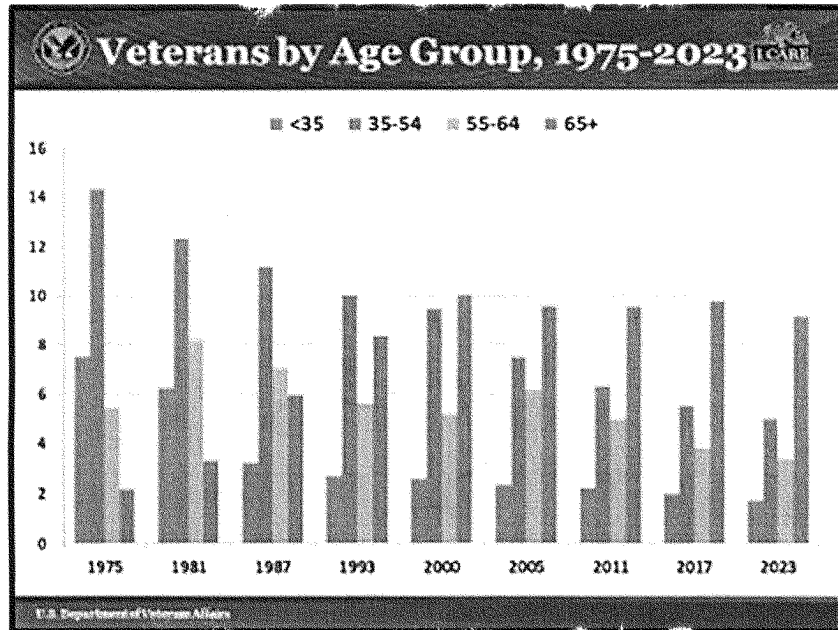
The trend of a growing demand for VA health care is fueled by more than a decade of war, Agent Orange-related disability claims, an unlimited claim appeal process, demographic shifts, increased medical issues claimed, and other factors. Additionally, survival rates among Americans who served in conflicts 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.

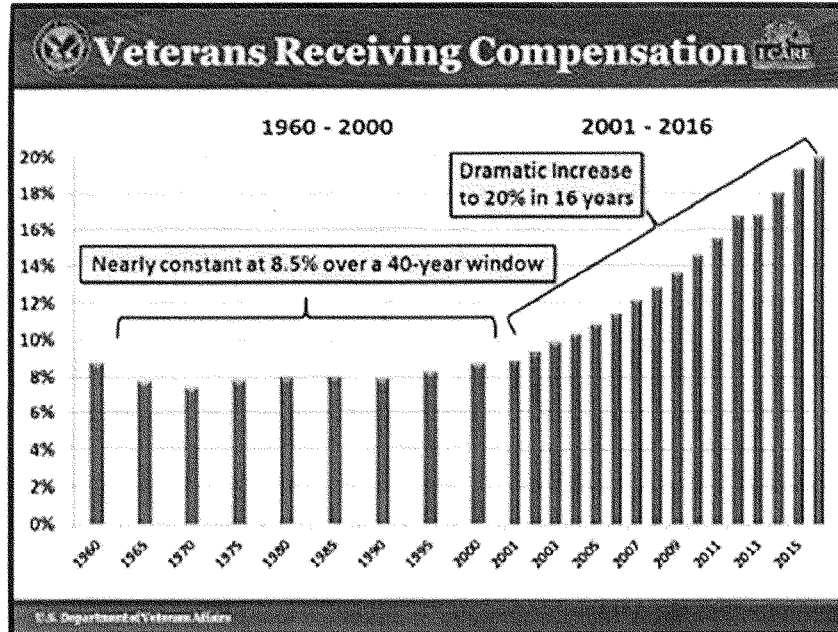
Compared to FY 2009, the number of patients is projected to increase by 22 percent by FY 2017. And, as Veterans see the results of VA's transformation, we are confident that the number of Veterans utilizing VA services will continue to rise. Currently, 11 million of the 22 million Veterans in this country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

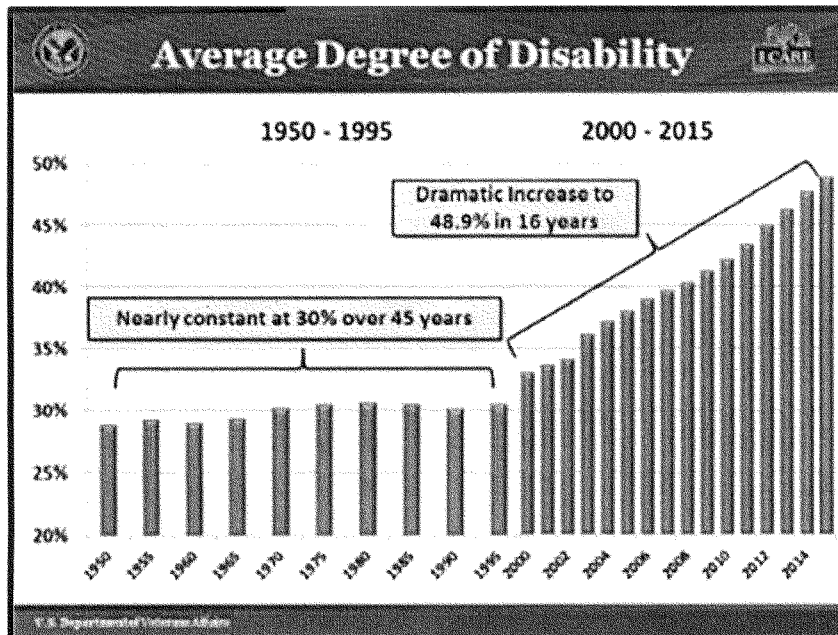


Today, there are an estimated 22 million Veterans. The number of Veterans is projected to decline to around 15 million by 2040. However, while the absolute number may decline, an aging Veteran population requires greater care, services, and benefits. In 2017, 46 percent (or 9.8 million) of the 22 million 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.

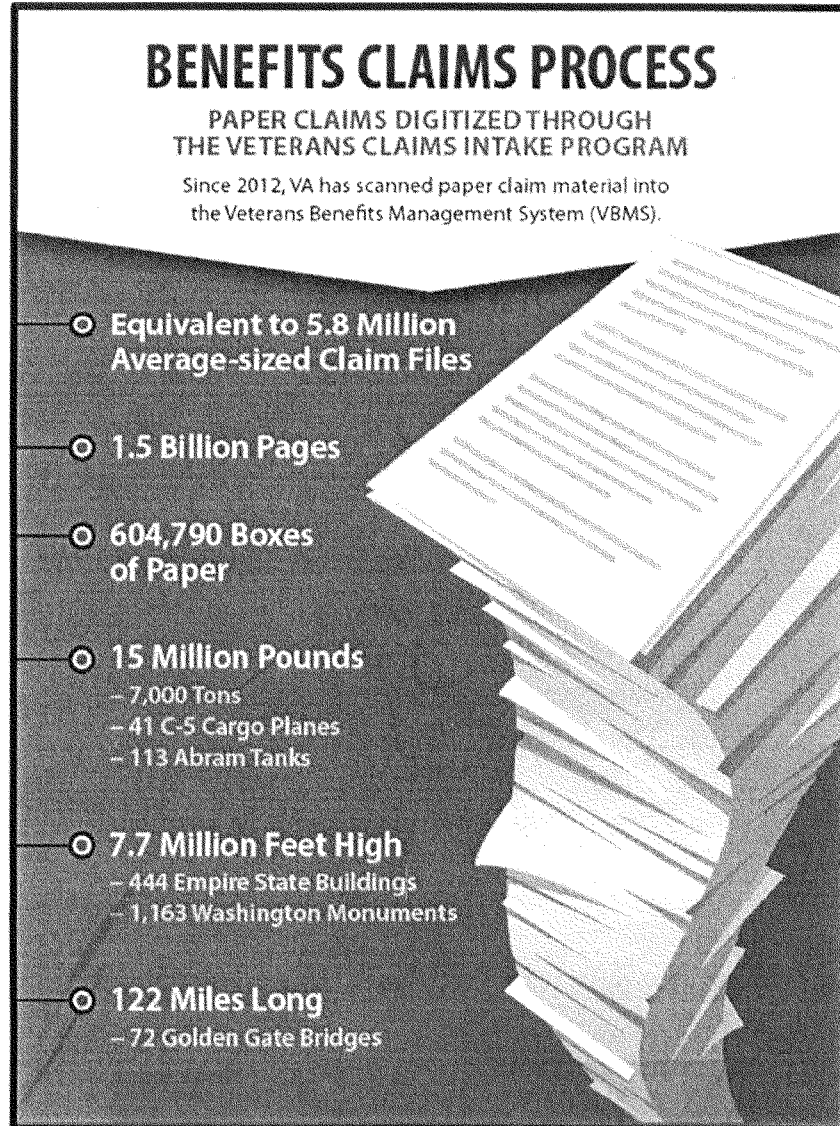


As VA continues to improve access and quality of care, more Veterans will come to VA for more of their care. Veterans today often choose VA for care either because of personal preference or because of VA's economic edge. Some 78 percent of enrolled Veterans at VA have other choices like Medicare, Medicaid,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

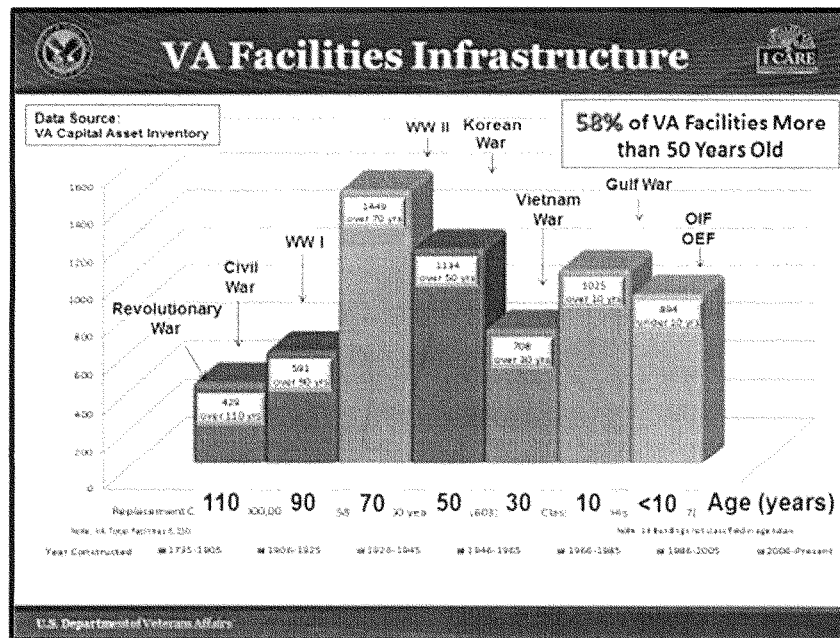
To strengthen financial management and stewardship, in FY 2015 VA launched its multi-year effort to replace VA's antiquated, 30-year-old core Financial Management System (FMS) with a 21st century system that will vastly improve VA financial management accuracy and transparency. The modernization effort 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 FTE, 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.

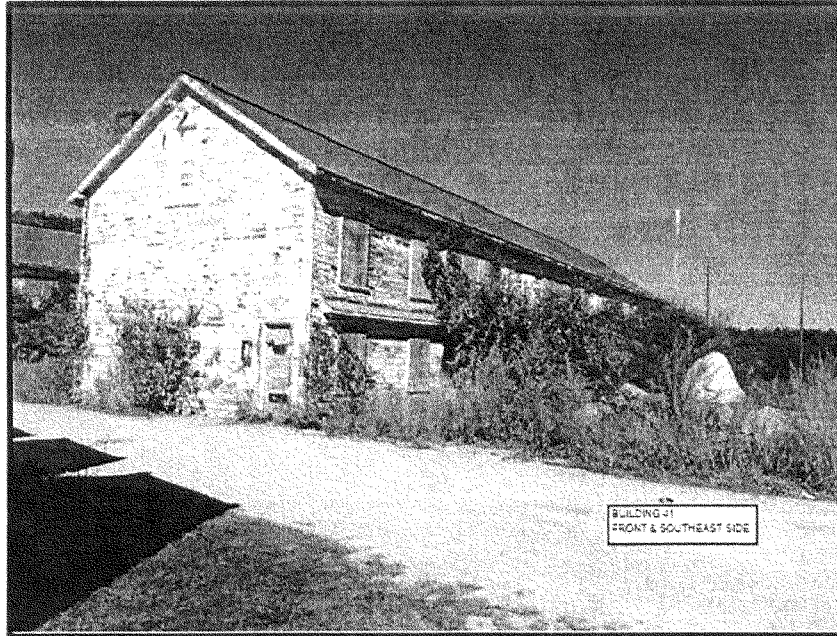
Recent challenges managing non-VA care program finances have demonstrated the great risks and immense burden of the FMS legacy system. FMS failure would severely impede the Department's ability to execute its budget, pay vendors and Veterans, and produce accurate financial statements.

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 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 Health Information Systems and Technology Architecture (VistA) Evolution. 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 35,000 patients with HCV. 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 percent 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 will include 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 initiative, 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.

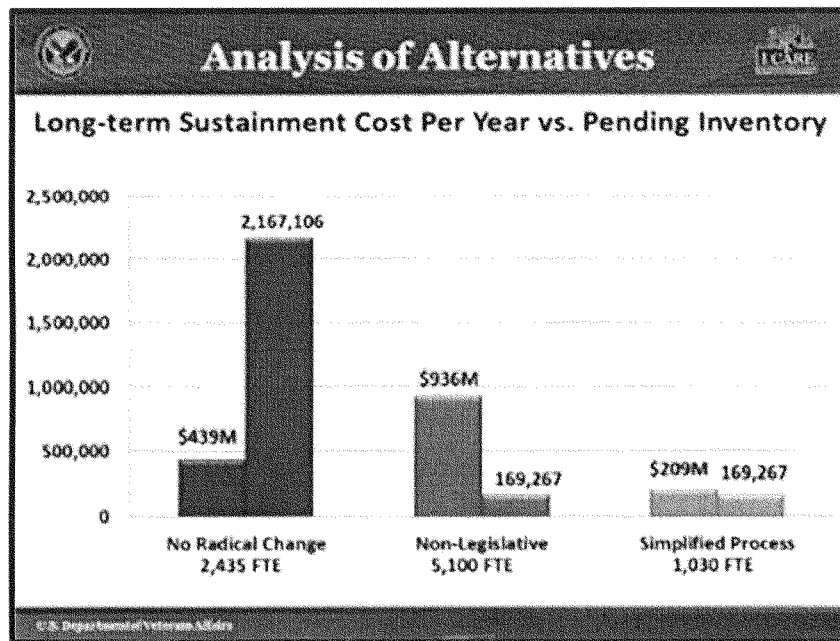
The Simplified Appeals Initiative

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 reso-

lution 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.

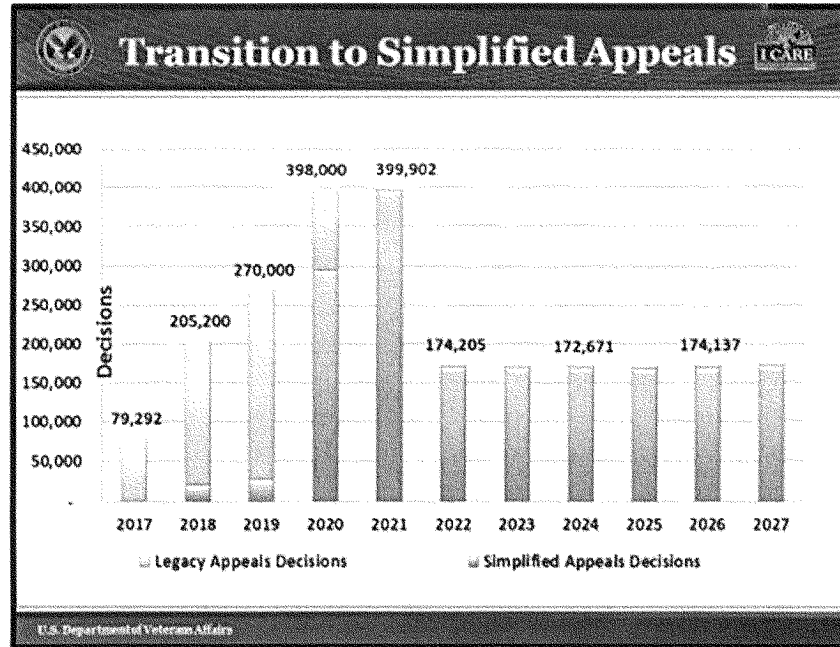
Fundamental legislative reform is essential to ensure that Veterans receive timely and quality appeals decisions, and we must begin an open, honest dialogue about what it will take for us to provide Veterans with the timely, fair, and streamlined appeals decisions they deserve. To put the needs, expectations, 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).

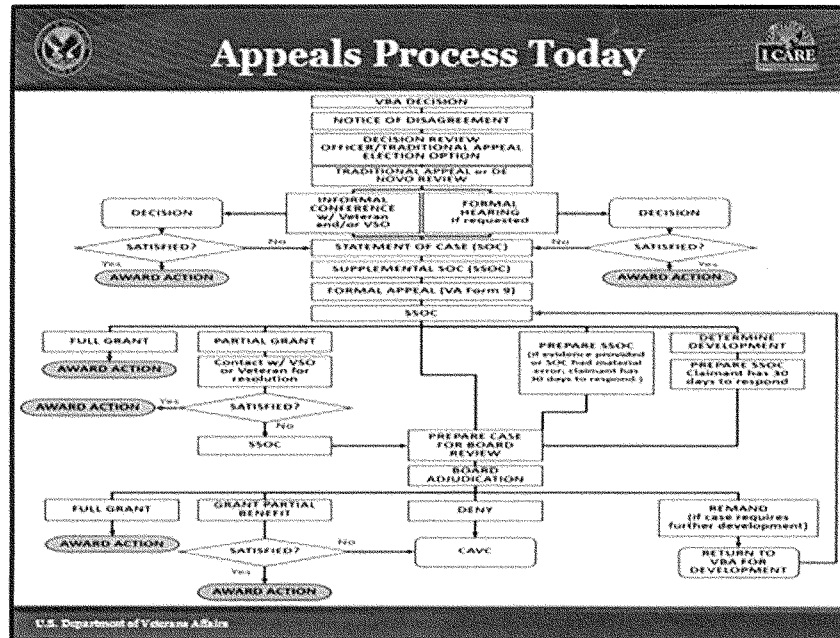
Without legislative change or significant increases in staffing, VA will face a soaring appeals inventory, and Veterans will wait even longer for a decision on their appeal. If Congress fails to enact VA's proposed legislation to simplify the appeals process, Congress would need to provide resources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



Simplified Appeals Process: Ramp Up and Long-Term Sustainment

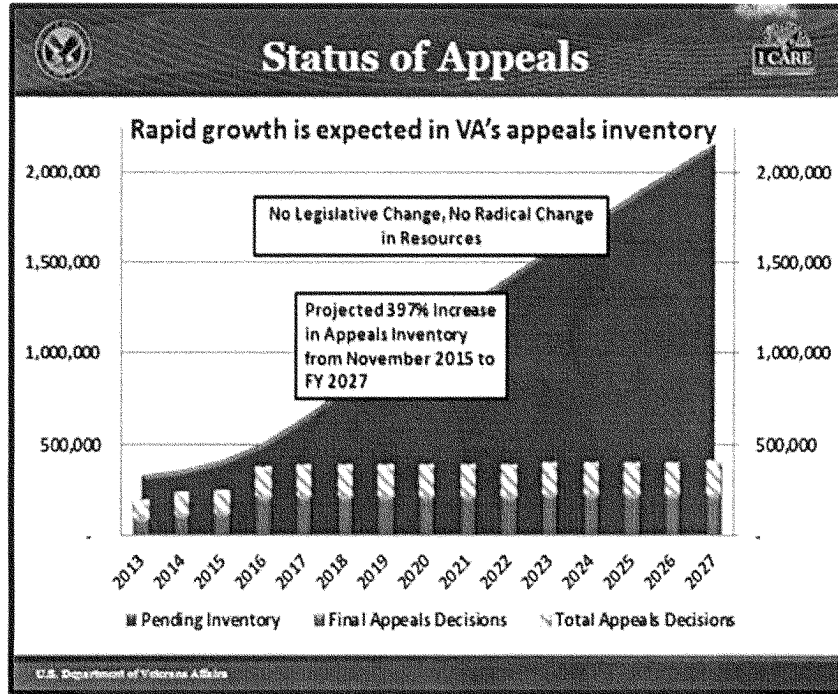
While the Simplified Appeals proposal would require FTE increases for the first several years to resolve the more than 440,000 currently pending appeals, by 2022, VA would be able to reduce appeals FTE to a sustainment level of roughly 1,030 FTE (including 980 FTE at the Board and 50 at VBA), a level 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.

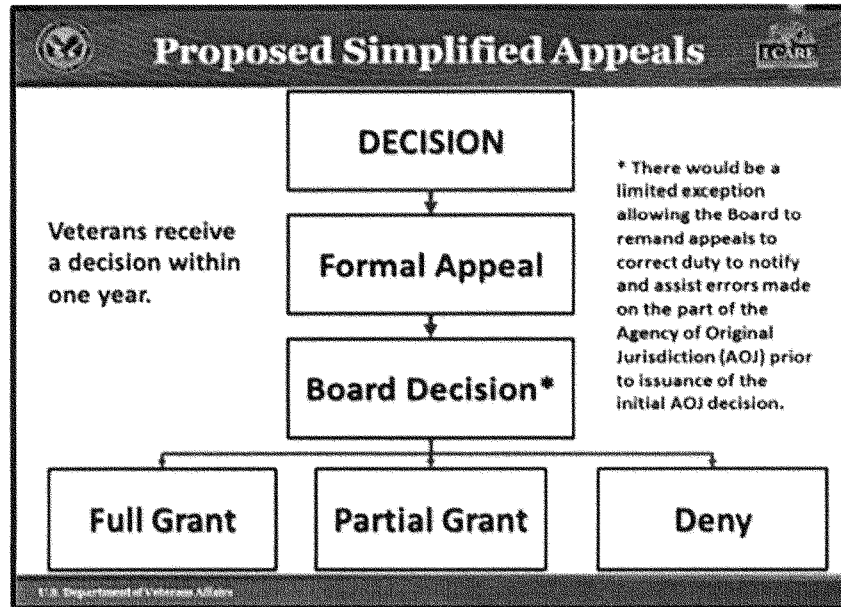


In today's Convolted Appeals Process, Veterans Wait 5 Years for a Decision

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 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.

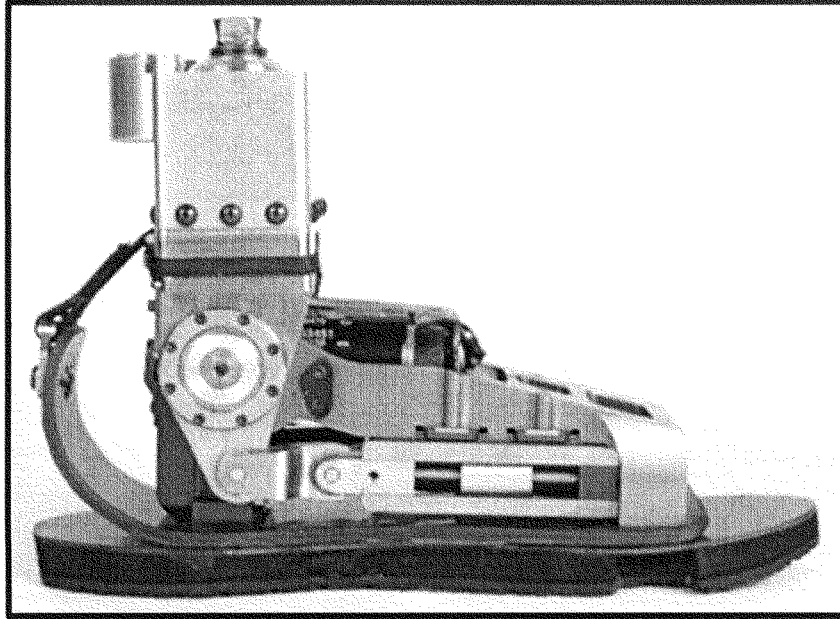


VA's Proposed Simplified Appeals Process: Veterans Receive an Appeal Decision Within One Year

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.

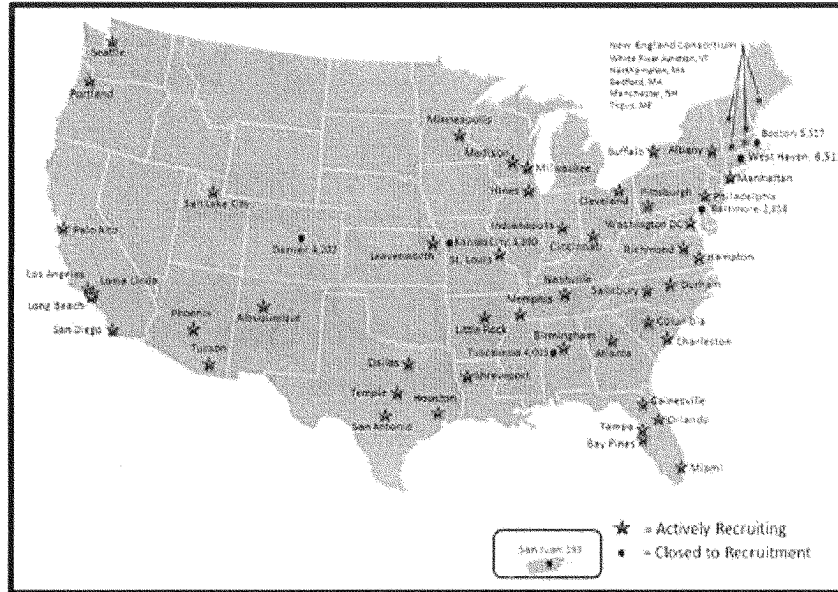
VA research is focused on the U.S. Veteran population and allows VA to uniquely address scientific questions to improve Veteran health care. Most VA researchers are also clinicians and health care providers who treat patients. Thus, VA research arises from the desire to heal rather than pure scientific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



The First Powered Ankle-Foot Prosthesis

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



VA's Million Veteran Program Recruitment

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.

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.



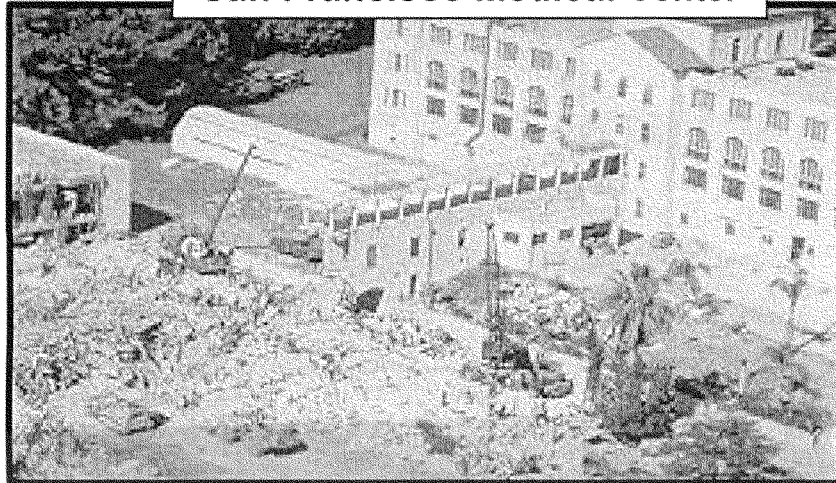
San Fernando Medical Center collapse, 1971

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.

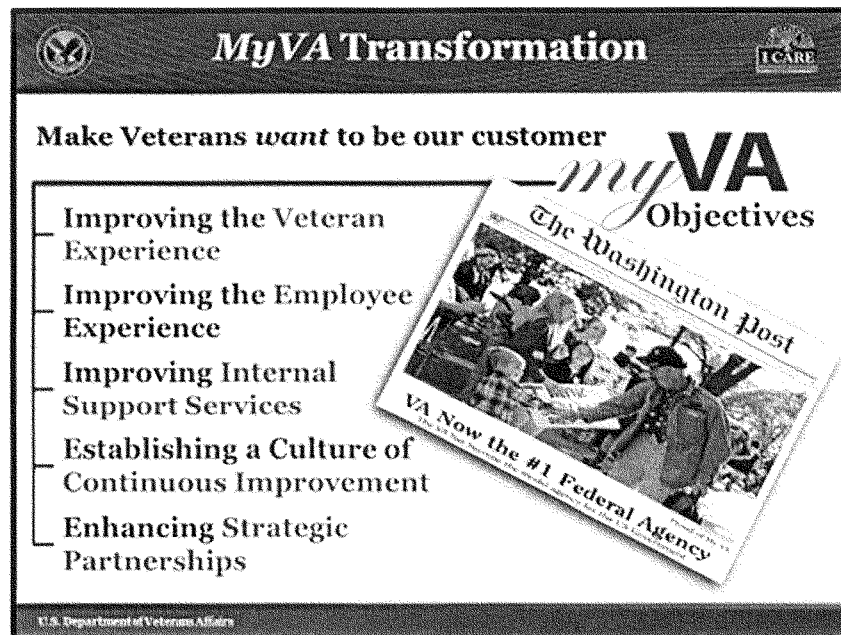
Leasing

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 coinci-

dence 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.

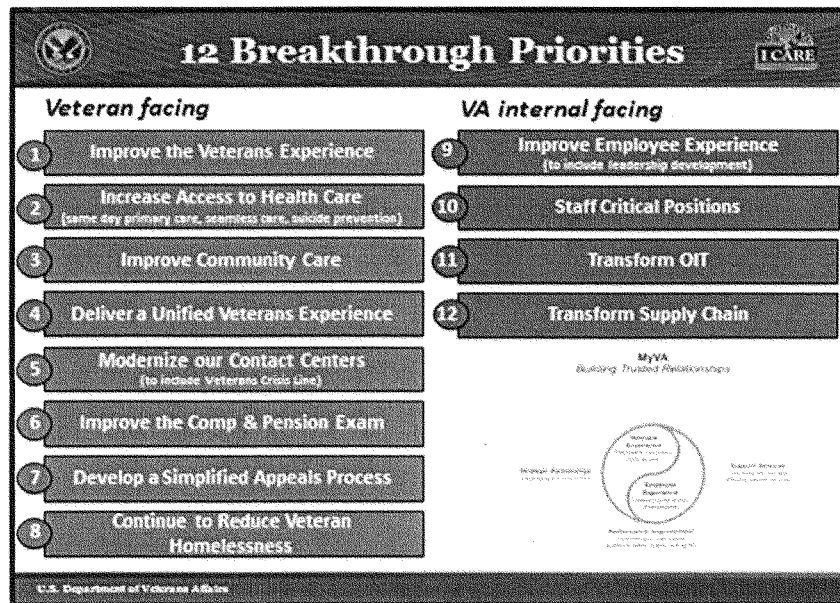
5. Enhancing strategic partnerships: Expanding our partnerships will allow us to extend the reach of services available for Veterans and their families. We must work effectively with those who bring capabilities and resources to help Veterans.

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 Web sites 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 will have a baseline satisfaction metric in place by the end of February and will set a goal for significant improvement once we know our baseline.
- 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 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. 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.

Statements For The Record

GOVERNMENT ACCOUNTABILITY OFFICE

Statement for the Record by Randall B. Williamson, Director, Health Care Letter

Chairman Miller, Ranking Member Brown, and Members of the Committee,

I am pleased to submit this statement on preliminary observations from our ongoing work examining the Department of Veterans Affairs' (VA) projected funding gap in its fiscal year 2015 medical services appropriation account. As you know, VA's Veterans Health Administration operates one of the largest health care delivery systems in the nation-serving about 6.6 million patients-and had total budgetary resources of nearly \$51 billion for medical services in fiscal year 2015. In June 2015, VA requested additional amounts from Congress because it projected a funding gap of about \$3 billion in its medical services appropriation account.¹ On July 31, 2015, the VA Budget and Choice Improvement Act provided VA temporary authority to use up to \$3.3 billion from the Veterans Choice Program appropriation for obligations incurred for other specified medical services, starting May 1, 2015 and ending October 1, 2015, to address its fiscal year 2015 projected funding gap.² The Vet-

¹In this statement, the projected funding gap refers to the period in fiscal year 2015 when VA's obligations for medical services were projected to exceed its available budgetary authority for that purpose for that year. The Antideficiency Act prohibits agencies from incurring obligations in excess of available budget authority. 31 U.S.C. § 1341(a). An obligation is defined as a "definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States." GAO, A Glossary of Terms Used in the Federal Budget Process, GAO 05 734SP (Washington, D.C.: September 2005), p. 70. We did not determine whether an Antideficiency Act violation occurred, as such an evaluation was beyond the scope of our ongoing work.

²Pub. L. No. 114-41, §§ 4001, 4004, 129 Stat. 443, 463-464 (2015).

erans Choice Program, which was established by statute in 2014, generally allows veterans to obtain care from a network of providers when their local VA medical centers (VAMC) cannot provide the services due to long wait times or the distance from veterans' homes.³

We and others have reported on past challenges VA has faced regarding the reliability, transparency, and consistency of its budget estimates for medical services used to support the President's budget request, as well as the agency's ability to accurately track obligations for medical services. For example, in February 2012, we reported that VA's estimated savings from operational improvements for providing medical services-used to support both the President's budget request for fiscal year 2012 and VA's advance appropriations request for fiscal year 2013-lacked analytical support or were flawed, raising questions regarding the reliability of the estimated savings.⁴ In addition, according to VA's 2014 Performance and Accountability Report, VA has financial system deficiencies and lacks an adequate process to validate its reported obligations.⁵ In light of these challenges, coupled with VA's fiscal year 2015 projected funding gap, members of Congress have questioned VA's ability to accurately estimate its budgetary needs for future years and track its obligations for medical services.

My statement today will discuss our preliminary observations on

1. the activities or programs that accounted for VA's fiscal year 2015 projected funding gap in its medical services appropriation account, and

2. changes VA has made to prevent potential funding gaps in future years.

My statement today is based on our ongoing work examining VA's fiscal year 2015 projected funding gap in its medical services appropriation account. To examine the activities or programs that accounted for this projected funding gap, we reviewed fiscal year 2015 obligation data and documents provided by VA, including requests for VA's fiscal year 2015 and 2016 budgets; VA's requests to Congress for the authority to transfer funds between its appropriations; internal memos and communications; and documents related to the projection model used by VA to estimate the utilization of and associated costs for activities funded through its medical services appropriation account. We analyzed this information to examine the activities or programs in VA's medical services budget that accounted for the projected funding gap in fiscal year 2015, as well as the extent to which and reasons that each activity or program contributed to the projected funding gap. We also interviewed officials from VA and the Office of Management and Budget (OMB) to identify the steps taken to address the projected funding gap.

To examine the changes VA has made or is planning to make to help prevent potential funding gaps in future years, we obtained and reviewed VA documents, including VA policy memoranda and internal reports, and interviewed VA officials. We analyzed this information to identify new or updated processes for projecting future budgetary needs and tracking obligations. We conducted a data reliability assessment of VA's fiscal year 2015 obligation data that we used, which included checks for missing values and outliers, and interviewed officials from the Office of Finance within the Veterans Health Administration, who are knowledgeable about the data. As a result of these steps, we determined that the data were sufficiently reliable for our objectives. We obtained the views of VA officials on the information provided in this statement and incorporated their comments, as appropriate.

The work upon which this statement is based is being conducted in accordance with generally accepted government auditing standards.

Background

VA provides medical services to various veteran populations-including an aging veteran population and a growing number of younger veterans returning from the

³To address concerns about long wait times for care, in 2014, the Veterans Access, Choice, and Accountability Act of 2014 was enacted to, among other things, establish the Veterans Choice Program. Pub. L. No. 113-146, § 101, 128 Stat. 1754, 1755-1765 (2014).

⁴See GAO, VA Health Care: Methodology for Estimating and Process for Tracking Savings Need Improvement, GAO 12 305 (Washington, D.C.: Feb. 27, 2012). Proposed savings included savings from operational improvements and management initiatives that are included in VA's budget justifications. The Veterans Health Care Budget Reform and Transparency Act of 2009 provided that VA's annual appropriations for health care also include advance appropriations that become available 1 fiscal year after the fiscal year for which the appropriations act was enacted. Pub. L. No. 111-81, § 3, 123 Stat. 2137, 2137-38 (2009), codified at 38 U.S.C. § 117. The act provided for advance appropriations for VA's Medical Services, Medical Support and Compliance, and Medical Facilities appropriations accounts and directed VA to include with information it provides Congress in connection with the annual appropriations process detailed estimates of funds needed to provide its health care services for the fiscal year for which advance appropriations are to be provided.

⁵See VA, 2014 Performance and Accountability Report (Washington, D.C.: Nov. 12, 2014).

military operations in Afghanistan and Iraq. VA operates approximately 170 VAMCs, 130 nursing homes, and 1,000 outpatient sites of care. In general, veterans must enroll in VA health care to receive VA's medical benefits package—a set of services that includes a full range of hospital and outpatient services, prescription drugs, and long-term care services provided in veterans' own homes and in other locations in the community.

The majority of veterans enrolled in the VA health care system receive care in VAMCs and community-based outpatient clinics, but VA may authorize care through community providers to meet the needs of the veterans it serves. For example, VA may provide care through its Care in the Community (CIC) program, such as when a VA facility is unable to provide certain specialty care services, like cardiology or orthopedics.⁶ CIC services must generally be authorized by a VAMC provider prior to a veteran receiving care. In addition to the CIC program, VA may also provide care to veterans through the Veterans Choice Program, which was established through the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), enacted on August 7, 2014.⁷ Implemented in fiscal year 2015, the program generally provides veterans with access to care by non-VA providers when a VA facility cannot provide an appointment within 30 days or when veterans reside more than 40 miles from the nearest VA facility. The Veterans Choice Program is primarily administered using contractors, who, among other things, are responsible for establishing nationwide provider networks and scheduling appointments for veterans. The Choice Act created a separate account known as the Veterans Choice Fund, which cannot be used to pay for VA obligations incurred for any other program, such as CIC, without legislative action.⁸ The Choice Act appropriated \$10 billion to be deposited in the Veterans Choice Fund. Amounts deposited in the Veterans Choice Fund are available until expended and are available for activities authorized under the Veterans Choice Program. However, the Veterans Choice Program activities are only authorized through fiscal year 2017 or until the funds in the Veterans Choice Fund are exhausted, whichever occurs first.⁹

As part of the President's request for funding to provide medical services to veterans, VA develops an annual budget estimate detailing the amount of services it expects to provide as well as the estimated cost of providing those services. VA uses the Enrollee Health Care Projection Model (EHCPM) to develop most of the agency's estimates of the budgetary needs to meet the expected demand for VA medical services.¹⁰ Like many other agencies, VA begins to develop these estimates approximately 18 months before the start of the fiscal year for which funds are provided. Different from many agencies, VA's Veterans Health Administration receives advance appropriations for health care in addition to annual appropriations. VA's EHCPM makes these projections 3 or 4 years into the future for budget purposes based on data from the most recent fiscal year. In 2012, for example, VA used actual fiscal year 2011 data to develop the budget estimate for fiscal year 2014 and the advance appropriation estimate for fiscal year 2015. Similarly, in 2013, VA used actual fiscal year 2012 data to update the budget estimate for fiscal year 2015 and develop the advance appropriation estimate for fiscal year 2016. Given this process, VA's budget estimates are prepared in the context of uncertainties about the future—not only about program needs, but also about future economic conditions, presidential policies, and congressional actions that may affect the funding needs in the year for which the estimate is made—which is similar to budgeting practices of other federal agencies. Further, VA's budget estimates are typically revised during the budget formulation process to incorporate legislative and department priorities as well as in response to successively higher level of reviews in VA and OMB.

Each year, Congress provides funding for VA health care primarily through the following appropriation accounts:

- Medical Services, which funds, among other things, health care services provided to eligible veterans and beneficiaries in VA's medical centers, outpatient

⁶VA has purchased health care services from community providers since as early as 1945. Before 2015, VA referred to its CIC program as “non-VA medical care” or “fee basis care.”

⁷Pub. L. No. 113–146, 128 Stat. 1754 (2014).

⁸Pub. L. No. 113–146, § 802, 128 Stat. 1754, 1802–1803 (2014). It was outside the scope of our ongoing review to evaluate VA's determinations to authorize an episode of care by non-VA providers under the Veterans Choice Program as opposed to CIC.

⁹Pub. L. No. 113–146, § 802(d), 128 Stat. 1754, 1802 (2014).

¹⁰The EHCPM's estimates are based on three basic components: the projected number of veterans who will be enrolled in VA health care, the projected quantity of health care services enrollees are expected to use, and the projected unit cost of providing these services. Unit costs are the costs to VA of providing a unit of service, such as a 30-day supply of a prescription or a day of care at a medical facility.

clinic facilities, contract hospitals, state homes, and outpatient programs on a fee basis.¹¹ The CIC program is funded through this appropriation account.

- Medical Support and Compliance, which funds, among other things, the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities authorized under VA's health care system.
- Medical Facilities, which funds, among other things, the operation and maintenance of the Veterans Health Administration's capital infrastructure, such as costs associated with nonrecurring maintenance, utilities, facility repair, laundry services, and groundskeeping.¹²

Higher-than-Expected Obligations for the CIC Program and Hepatitis C Drugs Accounted for VA's Fiscal Year 2015 Projected Funding Gap

Higher-than-Expected Obligations for the CIC Program Accounted for 85 Percent of VA's Projected Fiscal Year 2015 Funding Gap

Our preliminary work suggests that the higher-than-expected obligations identified by VA in April 2015 for VA's CIC program accounted for \$2.34 billion (or 85 percent) of VA's projected funding gap of \$2.75 billion in fiscal year 2015.¹³ These higher-than-expected obligations for the CIC program were driven by an increase in utilization of VA medical services across VA, reflecting, in part, VA's efforts to improve access to care after public disclosure of long wait times at VAMCs. VA officials expected that the Veterans Choice Program would absorb much of the increased demand from veterans for health care services delivered by non-VA providers. However, veterans' utilization of Veterans Choice Program services was much lower than expected in fiscal year 2015. VA had estimated that obligations for the Veterans Choice Program in fiscal year 2015 would be \$3.2 billion, but actual obligations totaled only \$413 million. Instead, VA provided a greater amount of services through the CIC program, resulting in total obligations of \$10.1 billion, which VA officials stated were much higher than expected for that program in fiscal year 2015.¹⁴ According to VA officials, the lower-than-expected utilization of the Veterans Choice Program in fiscal year 2015 was due, in part, to administrative weaknesses, such as provider networks that had not been fully established, that slowed enrollment in the program and that VAMC staff lacked guidance on when to refer veterans to the program.

The unexpected increase in CIC obligations in fiscal year 2015 exposed weaknesses in VA's ability to estimate costs for CIC services and track associated obligations. While VA officials first became concerned that CIC obligations might be significantly higher than projected in January 2015, they did not determine that VA faced a projected funding gap until April 2015—6 months into the fiscal year. They made this determination after they compared authorizations in the Fee Basis Claims System (FBCS)—VA's system for recording CIC authorizations and estimating costs for this care—with obligations in the Financial Management System (FMS)—the centralized financial management system VA uses to track all of its obligations, including those for medical services. In its 2015 Agency Financial Report (AFR), VA's independent public auditor identified the following issues as contributing to a material weakness in estimating costs for CIC services and tracking CIC obligations:¹⁵

- VAMCs individually estimate costs for each CIC authorization and record these estimates in FBCS. This approach leads to inconsistencies, because each VAMC may use different methodologies to estimate the costs they record.¹⁶ Having

¹¹In this statement, when we refer to medical services provided by VA, we are referring only to the services funded through its Medical Services appropriation account, which is where VA projected its fiscal year 2015 funding gap.

¹²Nonrecurring maintenance is designed to correct, replace, upgrade, and modernize existing infrastructure and utility systems.

¹³At the end of the fiscal year, VA determined that the projected funding gap was lower than it had initially projected, because VA reduced or halted funding for non-essential projects to mitigate an initial \$3 billion projection.

¹⁴The total obligations of \$10.1 billion in fiscal year 2015 for the CIC program do not include the \$413 million in obligations for the Veterans Choice Program in that year.

¹⁵See VA, 2015 Agency Financial Report (Washington, D.C.: Nov. 16, 2015).

¹⁶A recent VA Office of Inspector General report found that the methods used to calculate estimated costs included Medicare rates, historical costs, and an optional cost estimation tool provided by the Chief Business Office within the Veterans Health Administration. This office is responsible for developing administrative processes, policy, regulations, and directives associated with the CIC program. The accuracy of estimates varied widely among these methodologies. See VA Office of Inspector General, Audit of the Veterans Health Administration's Non-VA Medical Care Obligations (Washington, D.C.: Jan. 12, 2015).

more accurate cost estimates for CIC authorizations is important to help ensure that VA is aware of the amount of money it must obligate for CIC services.

- VAMCs do not consistently adjust estimated costs associated with authorizations for CIC services in a timely manner to ensure greater accuracy, and they do not perform a “look-back” analysis of historical obligations to validate the reasonableness of estimated costs. Furthermore, centralized, consolidated, and consistent monitoring of CIC authorizations is not performed.
- FBCS is not fully integrated with VA’s systems for recording and tracking the department’s obligations. Notably, the estimated costs of CIC authorizations recorded in FBCS are not automatically transmitted to VA’s Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement (IFCAP) system, a procurement and accounting system used to send budgetary information, such as obligations, to FMS. According to VA officials, because FBCS and IFCAP are not integrated, at the beginning of each month, VAMC staff must record in IFCAP estimated obligations for outpatient CIC services, and they use historical obligations for this purpose.¹⁷ Depending on the VAMC, these estimated obligations may be entered as a single lump sum covering all outpatient care or as separate estimated obligations for each category of outpatient care, such as radiology. Regardless of how they are recorded, the estimated obligations recorded in IFCAP are often inconsistent with the estimated costs of CIC authorizations recorded in FBCS. In fiscal year 2015, the estimated obligations that VAMCs recorded in IFCAP were significantly lower than the estimated costs of outpatient CIC authorizations recorded in FBCS. VA officials told us that they did not determine a projected funding gap until April 2015, because they did not complete their analysis of comparing estimated obligations with estimated costs until then.

In addition, the Chief Business Office (CBO) within the Veterans Health Administration, which is responsible for developing administrative processes, policy, regulations, and directives associated with the CIC program, had not developed and implemented standardized and comprehensive policies for VAMCs, regional networks, and the office itself to follow when estimating costs for CIC authorizations and for monitoring authorizations and associated obligations.¹⁸ This contributed to the material weaknesses the independent public auditor identified in the AFR. The AFR and VA officials we interviewed stated that because CIC was consolidated under CBO in fiscal year 2015 pursuant to the Choice Act, CBO did not have adequate time to implement efficient and effective procedures for monitoring CIC obligations.

To address the fiscal year 2015 projected funding gap, on July 31, 2015, VA obtained temporary authority to use up to \$3.3 billion in Veterans Choice Program funds for obligations incurred for medical services from non-VA providers, whether authorized under the Veterans Choice Program or CIC, starting May 1, 2015 and ending October 1, 2015.¹⁹ Based on our preliminary work, Table 1 shows the sequence of events that led to VA’s request for and approval of additional budget authority for fiscal year 2015.

¹⁷ In contrast, obligations corresponding to inpatient CIC authorizations are automatically recorded into IFCAP when the authorization is entered into FBCS. Officials told us that the high volume of outpatient CIC authorizations compared to the relatively lower volume of inpatient CIC authorizations, among other issues, makes it impossible to automate the process for recording outpatient CIC obligations using the existing systems.

¹⁸ VA’s regional networks manage VAMCs within their network.

¹⁹ Of this amount, not more than \$500 million could be used to pay for drug expenses relating to the treatment of hepatitis C. Pub. L. No. 114–41, § 4004, 129 Stat. 443, 463 (2015).

Table 1: Timeline of Actions Taken to Address the Department of Veterans Affairs' (VA) Higher-than-Expected Obligations for Care in the Community (CIC) Program in Fiscal Year 2015

Date	Action taken
January 2015	VA officials stated that they first became concerned that CIC obligations might be significantly higher than projected. Officials discovered that authorizations for CIC, which are recorded in the Fee Basis Claims System (FBCS), had increased between 30 and 40 percent compared to the same period in the prior year, while obligations recorded in the Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement (IFCAP) system and transmitted to the Financial Management System (FMS) had not increased correspondingly. (a).
January - April 2015	VA officials told us that, upon discovering the discrepancy between authorizations and obligations, VA undertook efforts to determine the cause of the discrepancy by comparing its authorizations in FBCS with obligations in FMS. VA officials stated that this process involved analyzing millions of transactions and was complicated by the lack of interoperability between FBCS and FMS..
April 2015	VA officials determined that CIC obligations were underreported in FMS, were projected to exceed the program's budgetary resources as currently allotted, and estimated this would result in a projected funding gap. (b).
May 2015	VA explored whether it had other budgetary resources available to address its projected funding gap and reduced or halted funding for non-essential projects..
May - June 2015	Officials stated that VA asked the Office of Management and Budget whether unobligated balances from prior years in other appropriation accounts could be used to address the projected funding gap. VA was informed that this was not possible..
June 2015	VA notified the Senate and House Committees on Veterans Affairs of its projected funding gap of about \$3 billion-of which it attributed \$2.5 billion to its CIC program-and requested temporary authority to use Veterans Choice Program funds for other purposes, specifically to cover the projected funding gap in VA's medical services appropriation account. (c).
July 2015	VA obtained temporary authority to use up to \$3.3 billion in Veterans Choice Program funding to cover the projected funding gap..
September 30, 2015	At the end of the fiscal year, VA determined that its projected funding gap was \$2.75 billion-of which VA attributed \$2.34 billion to its CIC program. This amount was lower than VA had initially projected, because VA reduced or halted funding for non-essential projects..

Source: GAO analysis based on VA documentation and interviews. ? GAO-16-374T.

(a) VA medical centers (VAMC) use FBCS to record CIC authorizations and estimate costs for this care. IFCAP is a decentralized procurement, funds control, and front-end accounting system. IFCAP transmits obligations to VA's FMS. VA uses FMS to track all of its obligations, including those for medical services.

(b) According to VA officials, VAMCs record obligations for outpatient CIC in IFCAP monthly, using historical obligations in each category of care, such as radiology. In contrast, obligations associated with inpatient CIC are automatically transmitted to IFCAP at the time the care is authorized in FBCS.

(c) In June 2015, VA officials provided the House Committee on Veterans Affairs with a spreadsheet outlining its expected obligations for CIC through the end of fiscal year 2015 compared to the amount budgeted for CIC at the beginning of the fiscal year. The amount budgeted for CIC, as reported to the committee, did not match the amount allocated for CIC in VA's budget justification, which was presented to Congress as part of the President's budget request in February 2015. VA officials told us that the amounts did not match because VA had made changes in how it defined its CIC program between the time the budget justification was developed and the beginning of fiscal year 2015, including reorganizing certain programs as a result of the Veterans Access, Choice, and Accountability Act of 2014 under the Chief Business Office, which is responsible for developing administrative processes, policy, regulations, and directives associated with the CIC program. VA officials were unable to fully reconcile the difference between the two amounts.

Unanticipated Obligations for Hepatitis C Drugs Contributed to the Remaining Portion of VA's Projected Fiscal Year 2015 Funding Gap

Our preliminary work also suggests that unexpected obligations for new hepatitis C drugs accounted for \$0.41 billion of VA's projected funding gap of \$2.75 billion

in fiscal year 2015.²⁰ Although VA estimated that obligations in this category would be \$0.7 billion that year, actual obligations totaled about \$1.2 billion.

VA officials told us that VA did not anticipate in its budget the obligations for new hepatitis C drugs -which help cure the disease-because the drugs were not approved by the Food and Drug Administration until fiscal year 2014, after VA had already developed its budget estimate for fiscal year 2015. The new drugs costs between \$25,000 and \$124,000 per treatment regimen, and according to VA officials demand for the treatment was high.²¹ Officials told us that about 30,000 veterans received these drugs in fiscal year 2015.

In October 2014, VA reprogrammed \$0.7 billion within its medical services appropriation account to cover projected obligations for the new hepatitis C drugs, after VA became aware of the drugs' approval. However, in January 2015, VA officials recognized that obligations for the new hepatitis C drugs would be significantly higher by year end than they expected. VA officials told us that they assessed next steps and then limited access to the drugs to those veterans with the most severe cases of hepatitis C. In June 2015, VA requested statutory authority to transfer funds dedicated to the Veterans Choice Program to VA's medical services appropriation account to cover the projected funding gap.

VA has Taken Steps to Better Track Obligations and Project Health Care Utilization, but Systems Deficiencies and Budgeting Uncertainties Remain

VA Has Taken Steps to Better Track Obligations, but Deficiencies Remain in the Systems for Tracking Obligations

Our preliminary work indicates that VA has developed new processes to prevent funding gaps for fiscal year 2016 and future years by improving its ability to track obligations for CIC services and hepatitis C drugs.

- In August 2015, VA issued a standard operating procedure to all VAMCs for recording estimated costs for inpatient and outpatient CIC in FBCS. The procedure, among other things, stipulates that VAMCs are to base estimated costs on historical cost data provided by VA. In addition, VA developed a software patch-released in December 2015 to all VAMCs-that automatically generates estimated costs for CIC authorizations, thereby eliminating the need for VAMC staff to individually estimate costs and record them in FBCS. According to VA officials, these changes should result in more accurate estimated costs for CIC authorizations. However, VA officials told us that accurately estimating the cost of CIC authorizations is challenging because of several unknown factors, such as the number of times a veteran may seek treatment for a recurring condition.²²
- In November 2015, VA allocated funds for CIC and hepatitis C drugs to each VAMC.²³ In addition, VA officials told us that to identify VAMCs that may be at risk for exhausting their funds before the end of the fiscal year, VA began tracking VAMCs' obligations for CIC and hepatitis C drugs through monthly reports. Officials from the Office of Finance within the Veterans Health Administration told us that once a VAMC had obligated its CIC and hepatitis C drug funds, it would have to request additional funds from VA. VA would, in turn, evaluate the validity of a VAMC's request and determine whether additional funds may be made available. This practice could limit veterans' access to CIC services or hepatitis C drugs in some locations. Officials told us that these steps are intended to reduce the risk of VAMCs obligating more funds than VA's budgetary resources allow.
- In November 2015, VA also issued a policy requiring VAMCs to identify and report on potentially inaccurate estimated costs for CIC authorizations recorded in FBCS and any discrepancies between estimated costs for CIC authorizations recorded in FBCS and the amount of estimated obligations recorded in FMS. According to VA officials, these discrepancies may signal a risk of VA under obligating funds for CIC, leaving VA potentially unable to pay for authorized care.

²⁰ In addition, VA faced unanticipated construction costs totaling \$875 million for the new Aurora, Colorado VAMC. VA reprogrammed funds in its medical services account, and with statutory authority, transferred funds from other VA appropriation accounts to cover these unanticipated construction costs.

²¹ VA officials told us that they were not aware of the cost of these drugs until after their approval.

²² A single authorization may allow for multiple episodes of care, such as up to 10 visits to a physical therapist. Alternatively, a veteran may choose not to seek the care that was authorized.

²³ VA officials told us that, after VA received its fiscal year 2016 appropriations in December 2015, VA increased the funds allocated to VAMCs.

VA's policy also requires VAMCs to address concerns identified by VAMCs in these reports—such as adjusting unreasonably low estimated costs for CIC authorizations and unreasonably low estimated obligations, to make the estimates more accurate. Under VA's new policy, network directors are required to certify monthly that the reports have been reviewed and concerns addressed.

VA officials told us that these new processes are necessary to help prevent future funding gaps because of the deficiencies in VA's systems for tracking obligations, which we have described previously.

Officials also told us that VA is exploring options for replacing IFCAP and FMS, which officials describe as antiquated systems based on outdated technology, and the department has developed a rough timeline and estimate of budgetary needs to make these changes. Officials told us that the timeline and cost estimate would be refined once concrete plans for replacing IFCAP and FMS are developed. Officials told us that replacing IFCAP and FMS is challenging due to the scope of the project and the requirement that the replacement system interface with various VA legacy systems, such as the Veterans Health Information Systems and Technology Architecture, VA's system containing veterans' electronic health records. However, as we have previously reported, VA has made previous attempts to update IFCAP and FMS that were unsuccessful. In October 2009, we attributed these failures to the lack of a reliable implementation schedule and cost estimates, among other factors, and made several recommendations aimed at improving program management.²⁴

VA is Using More Recent Data to More Accurately Project Future Health Care Utilization, but Budgetary Uncertainties Remain

Our preliminary work indicates that VA updated its EHCPM to include data from the first 6 months of fiscal year 2015, reflecting increased health care utilization in that year, which VA officials told us will inform VA's budget estimate for fiscal year 2017 and advance appropriations request for fiscal year 2018.²⁵ Without this change, VA would have used actual data from fiscal year 2014 to make its budget estimate and inform the President's budget request for fiscal years 2017 and 2018.

However, as we have previously reported, while the EHCPM projection informs most of VA's budget estimate, the amount of the estimate is determined by several factors, including the President's priorities. Historically, the final budget estimate for VA has consistently been lower than the amount projected for modeled services. VA officials told us that they expect any difference between the fiscal year 2017 budget estimate and the amount projected by VA's model to be made up by greater utilization of the Veterans Choice Program. However, VA's authority to use Veterans Choice Program funds is only available through fiscal year 2017 or until the funds are exhausted, whichever occurs first.

VA has also taken steps to help increase utilization of the Veterans Choice Program. VA issued policy memoranda to VAMCs in May and October 2015, requiring them to refer veterans to the program if timely care cannot be delivered by a VAMC, rather than authorizing care through the CIC program. With statutory authority, VA has also loosened restrictions on veterans' use of the Veterans Choice Program, eliminating the requirement that veterans must be enrolled in the VA health care system by August 2014 in order to receive care through the program.²⁶ While data from November 2015 indicate that utilization of care under the Veterans Choice Program has increased, VA officials expressed concerns that utilization would not reach the levels projected for fiscal year 2016 because of continuing weaknesses in implementing the program. For example, in November 2015, VA's Office of Compliance and Business Integrity identified extensive noncompliance among VAMCs with VA's policies for implementing the Veterans Choice Program and recommended training for VAMC staff responsible for implementing the program.²⁷ The office also recommended that VA establish internal controls to ensure compliance with VA's policies. As of January 2016, VA had not completed a plan for establishing these internal controls.

Like other health care payers, VA faces uncertainties estimating the cost of emerging health care treatments—such as costly drugs to treat chronic diseases affecting veterans. VA, like other federal agencies, prepares its budget estimate 18

²⁴ Previous unsuccessful attempts to update FMS include the Core Financial and Logistics System in 2004. See GAO, Information Technology: Actions Needed to Fully Establish Program Management Capability for VA's Financial and Logistics Initiative, GAO 10-40 (Washington, D.C.: Oct. 26, 2009).

²⁵ The President's Budget request for fiscal year 2016 and VA's fiscal year 2016 congressional budget justification had been submitted by the time officials realized that VA faced a projected funding gap for its medical services appropriation account in fiscal year 2015.

²⁶ Pub. L. No. 114-41, § 4005(b), 129 Stat. 443, 464 (2015).

²⁷ This office provides internal oversight of the VAMCs' revenue and CIC operations.

months in advance of the start of the fiscal year for which funds are provided. At the time VA develops its budget estimate, it may not have enough information to estimate the likely costs for health care services or these treatments with reasonable accuracy. However, by establishing appropriate internal controls, VA can help reduce the risks associated with the weaknesses in its budgetary projections and monitoring.

Chairman Miller, Ranking Member Brown, and Members of the Committee, this concludes my statement for the record.

GAO Contacts & Staff Acknowledgments

If you or your staff members have any questions concerning this statement, please contact Randall B. Williamson, Director, Health Care, at 202-512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Rashmi Agarwal, Assistant Director; Luke Baron; Krister Friday; Jacquelyn Hamilton; and Michael Zose.

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GAO Highlights

Highlights of GAO-16-374T, a statement for the record to the Committee on Veterans Affairs, House of Representatives

Why GAO Did This Study

VA projected a funding gap in its fiscal year 2015 medical services appropriation account and obtained temporary authority to use up to \$3.3 billion in Veterans Choice Program funding to close this gap. GAO was asked to examine VA's fiscal year 2015 projected funding gap and changes VA has made to help prevent potential funding gaps in future years.

This statement is based on GAO's ongoing work and provides preliminary observations on (1) the activities or programs that accounted for VA's fiscal year 2015 projected funding gap in its medical services appropriation account and (2) changes VA has made to prevent potential funding gaps in future years. GAO reviewed data VA provided on its obligations and related documents to determine what activities accounted for the projected funding gap in its fiscal year 2015 medical services appropriation account, as well as the factors that contributed to the projected funding gap. GAO interviewed VA and Office of Management and Budget officials to identify the steps taken to address the projected funding gap. GAO also examined changes VA made to better track obligations and project future budgetary needs.

GAO shared the information provided in this statement with VA and incorporated its comments as appropriate.

VA'S HEALTH CARE BUDGET

Preliminary Observations on Efforts to Improve Tracking of Obligations and Projected Utilization

What GAO Found

GAO's ongoing work indicates that two areas accounted for the Department of Veterans Affairs' (VA) fiscal year 2015 projected funding gap of \$2.75 billion. Specifically,

- Higher-than-expected obligations for VA's longstanding care in the community (CIC) program—which allows veterans to obtain care from providers outside of VA facilities—accounted for \$2.34 billion or 85 percent of VA's projected funding gap. VA officials expected that the new Veterans Choice Program—which was implemented in fiscal year 2015 and also allows veterans to access care from non-VA providers under certain conditions—would absorb veterans' increased demand for care after public disclosure of long wait times. However, administrative weaknesses slowed enrollment into this new program. The unexpected increase in CIC obligations also exposed VA's weaknesses in estimating costs for CIC services and tracking associated obligations. VA officials did not determine that VA faced a projected funding gap until April 2015—6 months into the fiscal year, after they compared estimated authorizations with estimated obligations for CIC.
- Unanticipated obligations for hepatitis C drugs accounted for the remaining portion—\$408 million—of VA's projected funding gap. VA did not anticipate in its budget the obligations for these costly, new drugs, which can help cure the disease, because the drugs did not gain approval from the Food and Drug Administration until fiscal year 2014—after VA had already developed its budget estimate for fiscal year 2015. VA officials told GAO that in fiscal year 2015 about 30,000 veterans received these drugs, which cost between \$25,000 and \$124,000 per treatment regimen.

GAO's ongoing work indicates that VA has taken steps to better track obligations and project future healthcare utilization, but systems deficiencies and budgetary uncertainties remain. Specifically, GAO's preliminary results indicate that VA has taken the following steps:

- VA issued a standard operating procedure to help VA medical centers (VAMC) more accurately estimate the costs associated with authorizations for CIC.

- VA directed VAMCs to compare their estimated costs for CIC authorizations with estimated obligations for CIC on a monthly basis.
- VA allocated funds to each VAMC for CIC and hepatitis C drugs and began tracking VAMCs' obligations with monthly reports. Officials told GAO that once a VAMC has obligated its funds, it would have to request additional funds. VA would determine whether additional funds may be made available. These processes are necessary because continued deficiencies in VA's financial systems present challenges in tracking of obligations.
- VA updated the model it uses to inform most of its budget estimates for medical services. It now includes more recent data that reflect increased healthcare utilization among veterans in fiscal year 2015. However, VA officials noted uncertainties remain about the forecasted utilization of the Veterans Choice Program and emerging health care treatments, which could affect the accuracy of the health care budget estimates.

THE INDEPENDENT BUDGET

Budget Recommendations for FY 2017 and FY 2018

Introduction

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

The Independent Budget veterans' service organizations (IBVSOs) recognize that Congress and the Administration continue to face immense pressure to reduce federal spending. However, we believe that the ever-growing demand for health care and benefits services provided by the VA certainly validates the continued need for sufficient funding. We understand that VA has fared better than most federal agencies in budget proposals and appropriations.

In the past couple of years, as many federal agencies have faced reductions in funding, the Administration has continued to request increases to discretionary funding for VA. At the same time, Congress has continued to provide increases in appropriations dollars. However, the serious access problems in the health care system identified in 2014 and the continued pressure being placed on the claims processing system raise serious questions about the resources being provided and how VA chooses to spend these resources. In fact, Deputy Secretary Gibson affirmed on multiple occasions that for too long VA has been "managing to budget, not to need." This is an unacceptable practice for an agency charged with meeting the needs of veterans who have served and sacrificed.

The IBVSOs are jointly releasing this stand-alone report that focuses solely on the budget of VA and our projections for the VA's funding needs across all programs. This report is not meant to suggest that these are the absolute correct answers for funding these services. However, in submitting our recommendations the IBVSOs are attempting to produce an honest assessment of need that is not subject to the politics of federal budget development and negotiations that inevitably have led to continuous funding deficits.

Our recommendations include funding for all discretionary programs for FY 2017 as well as advance appropriations recommendations for medical care accounts for FY 2018. Our recommendations reflect our concerns with obtaining adequate funding levels for the VA in light of the massive shortfall that the VA faced last summer. It affirms the need for added emphasis on properly staffing the health care system and building capacity, particularly in the spinal cord injury system of care that serves the largest single inpatient population of veterans. We hope that the House and Senate Committees on Veterans' Affairs as well as the Military Construction and Veterans' Affairs Appropriations Subcommittees will be guided by these estimates in making their decisions to ensure sufficient, timely, and predictable funding for VA.

VA Accounts for FY 2017 and FY 2018 Advance Appropriations

	FY 2016 Approp- riation	FY 2017 Ad- vance Approps	FY 2017 Admin Revised	FY 2017 IB	FY 2018 Ad- vance Approps	FY 2018 Ad- vance Approps
Veterans Health Administration (VHA)						
Medical Services	49,972,360	51,673,000	45,505,812	60,868,757	44,886,554	64,032,909
Medical Community Care Choice Program**	5,643,953		7,246,181		9,409,118	
			5,673,190			
Subtotal Medical Services	55,616,313	51,673,000	58,425,183	60,868,757	54,295,672	64,032,909
Medical Support and Compliance	6,144,000	6,524,000	6,222,894	6,654,480	6,654,480	6,314,266
Medical Facilities	5,020,132	5,074,000	5,723,000	5,742,036	5,434,880	6,683,603
Subtotal Medical Care, Discretionary	66,780,445	63,271,000	70,672,183	72,833,687	66,385,032	77,030,778
Medical Care Collections	3,515,171	3,299,954	3,558,307		3,627,255	
Total, Medical Care Budget Authority (including Collections)	70,295,616	66,570,954	74,230,490	72,833,687	70,012,287	77,030,778
Medical and Prosthetic Research	630,735		663,366	665,000		
Millions Veterans Program				75,000		
Total, Veterans Health Administration	70,926,351	66,570,954	74,893,856	73,573,687		
General Operating Expenses (GOE)						
Veterans Benefits Administration	2,707,734		2,826,160	3,056,353		
General Administration	336,659		417,959	345,623		
Board of Veterans Appeals	109,884		156,096	134,150		
Total, GOE	3,154,277		3,400,215	3,536,126		
Departmental Admin/ Misc. Programs						
Information Technology	4,133,363		4,278,259	4,209,053		
National Cemetery Administration	271,220		286,193	274,942		
Office of Inspector General	136,766		160,106	138,440		
Total, Dept. Admin/ Misc. Programs	4,541,349		4,724,558	4,622,435		

Construction Programs			
Construction, Major		528,110	1,500,000
Construction, Minor	1,243,800	372,069	749,000
Grants for State Extended Care Facilities	406,200	80,000	200,000
Grants for State Vets Cemeteries	120,000	45,000	52,000
Total, Construction Programs	1,816,000	1,025,179	2,501,000
Other Discretionary	166,090	201,000	168,000
Rescission to Joint Incentive Fund	-30,000		
Total, Discretionary Budget Authority (Including Medical Collections)	80,574,067	84,244,808	84,401,248

Veterans Health Administration

Total Medical Care

FY 2017 IB Recommendation	\$72.8 billion
FY 2017 Enacted Advance Appropriations	\$63.3 billion
Medical Care Collections	\$3.3 billion
Total Advance Appropriations	\$66.6 billion
FY 2017 Revised Administration Request	
**This amount includes approximately \$3.6 billion in Medical Care Collections and nearly \$5.6 billion in funding used under authorities of the Choice Act.	
Total	\$74.2 billion
FY 2018 IB Advance Appropriations Recommendation	\$77.0 billion
FY 2018 Administration Advance Appropriations Request	\$70.0 billion
Medical Care Collections	\$3.6 billion
Total	\$73.6 billion

The IBVSOs appreciate the fact that the Administration continues to present budget recommendations for the overall Medical Care accounts that address veterans' growing demand for health care services. Unfortunately, we believe the FY 2017 advance appropriation approved by Congress in the FY 2016 Consolidated and Further Continuing Appropriations Act is not sufficient to meet the full demand for services being placed on the system. For FY 2017, the IB recommends approximately \$72.8 billion in total medical care funding. Congress recently approved only \$66.6 billion for this account (including an assumption of approximately \$3.3 billion in medical care collections).

Of particular concern to the IBVSOs that VA continues to over-project and under-perform its medical care collections estimates. Overestimating medical care collections allows Congress to appropriate fewer discretionary dollars for the health care system. However, when VA fails to collect what VA originally estimated, it is left with insufficient funding to meet the actual demand by veterans. As long as this scenario continues, VA will find itself falling farther behind in its ability to care for enrolled veterans, the precise situation now occurring.

Similarly, we are concerned that the baseline for FY 2016 was not appropriately adjusted in the previous continuing appropriations bill to offset the severe shortfall the VA experienced last year. The underfunded baseline will assuredly have a serious negative downstream effect on funding for FY 2017 and FY 2018. We believe that it will be critical moving forward for VA to adjust its baseline for total Medical Care need to account for the much greater demand for services.

With these thoughts in mind, The Independent Budget also recommends approximately \$77.0 billion for total Medical Care for FY 2018. This recommendation reflects the necessary adjustment to the baseline for all Medical Care program funding in the preceding fiscal years.

Medical Services

Appropriations for FY 2017

FY 2017 IB Recommendation	\$60.9 billion
FY 2017 Revised Administration Request	
Medical Services	\$45.5 billion
Medical Community Care (New Proposed Account)	\$7.2 billion
Section 801 and 802 Choice Act Funds	\$5.7 billion
Medical Care Collections	\$3.6 billion
Total	\$58.4 billion
FY 2017 Enacted Advance Appropriations	\$51.7 billion
Medical Care Collections	\$3.6 billion
Total	\$55.3 billion

For FY 2017, The Independent Budget recommends \$60.9 billion for Medical Services. This recommendation is a reflection of multiple components. These components include the following recommendations:

Current Services Estimate.....\$57,114,044,000

Increase in Patient Workload.....	\$1,409,713,000
Additional Medical Care Program Cost.....	\$2,345,000,000
Total FY 2016 Medical Services.....	\$60,868,757,000

The current services estimate reflects the impact of projected uncontrollable inflation on the cost to provide services to veterans currently using the system. This estimate also assumes a 1.2 percent increase for pay and benefits across the board for all VA employees in FY 2017. The Administration recently announced an intention to provide a 1.6 percent comparability increase. The significant increase in our recommended funding also reflects an adjustment in the baseline for funding within the Medical Services account of approximately \$2.85 billion. The Independent Budget believes this adjustment is necessary in light of a more than \$3 billion shortfall that the VA health care system experienced last summer. The fact that VA provided 7 million more appointments last year—both within VA facilities and in the community—is further evidence of the dramatic rise in demand. If the baseline from FY 2016 is not adjusted to better reflect the true demand VA is experiencing, we believe the VA will inevitably face a severe shortfall again this fiscal year and next.

Our estimate of growth in patient workload is based on a projected increase of approximately 103,000 new unique patients. These patients include priority group 1≥8 veterans and covered non-veterans. We estimate the cost of these new unique patients to be approximately \$1.2 billion. The increase in patient workload also includes a projected increase of 53,150 new Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) enrollees, as well as Operation New Dawn (OND) veterans at a cost of approximately \$215 million. The increase in utilization among OEF/OIF/OND veterans is supported by the average annual increase in new users through the third quarter of FY 2015.

The Independent Budget believes that there are additional projected medical program funding needs for VA. Specifically, we believe there is real funding needed to address the array of long-term-care issues facing VA, including the shortfall in institutional capacity; critical resources to address the continually increasing demand for life-saving Hepatitis C treatments; to provide additional centralized prosthetics funding (based on actual expenditures and projections from the VA's Prosthetics and Sensory Aids Service); funding to expand and improve services for women veterans; as well as funding necessary to improve the Comprehensive Family Caregiver program. Similarly, VA must ensure that adequate funding is directed towards specialized services, to include the beds and staffing infrastructure for the spinal cord injury service which delivers lifetime care for a patient population that heavily relies on the VA health care system. Lack of commitment to these programs threatens the health and well-being of many of the most vulnerable populations of veterans.

Long-Term Services and Supports

The Independent Budget recommends \$285 million for FY 2017. This recommendation reflects the fact that there was a significant increase in the number of veterans receiving Long Term Services and Supports (LTSS) in 2015. Unfortunately, due to loss of authorities—specifically fee-care no longer being authorized, provider agreement authority not yet enacted, and the inability to use Choice funds for all but skilled nursing care—to purchase appropriate LTSS care particularly for home- and community-based care, we estimate an increase in the number of veterans using the more costly long-stay and short-stay nursing home care. This funding is particularly important to veterans with spinal cord injury/disease (SCI/D), as they tend to rely on inpatient LTSS that is far more complex than the average veteran. Unfortunately, SCI/D veterans are significantly underserved by VA's LTSS. We believe the Administration must demonstrate serious commitment to expanding capacity for long-term care for veterans with SCI/D.

Hepatitis C

We also recommend \$1.7 billion dedicated specifically to the goal of expanding treatment for veterans diagnosed with Hepatitis C. The VA previously projected a goal to treat 120,000 veterans with Hepatitis C between FY 2016 and FY 2018. In, FY 2017, VA is expected to treat as many as 50,000 veterans with a projected cost of approximately \$1.7 billion. This estimate also includes the assumption of a 10 percent cost reduction per veteran, which we believe the VA will be able to achieve through the introduction of newer and cheaper Hepatitis C medications, and if the VA renegotiates the price of current medications.

Prosthetics and Sensory Aids

In order to meet the increase in demand for prosthetics, the IB recommends an additional \$150 million. This increase in prosthetics funding reflects a similar in-

crease in expenditures from FY 2015 to FY 2016 and the expected continued growth in expenditures for FY 2017. With the development of new advanced prosthetics that will benefit veterans with the most catastrophic disabilities, such as loss of single or multiple limb functions, significant resources must be provided to support this advancement. Failure to do so will limit the options available to veterans with the greatest need.

Caregiver Support Program

Our increased program cost recommendation also includes \$120 million (above the projected baseline of \$605 million) for the Comprehensive Family Caregiver Program in FY 2017. The additional \$120 million for VA's Caregiver Program will provide for the steady rate of increase in the number of caregivers participating in the program, currently averaging between 350 and 400 per month. The amount recommended will also provide for a more robust number of Caregiver Support Coordinators to address issues regarding the program administration at local facilities. This will directly benefit an aging and severely disabled veteran population whose lives are significantly impacted by the availability of comprehensive VA Caregiver Support services.

Women Veterans

The Medical Services appropriation should be supplemented with \$90 million designated for women's health care programs, in addition to those amounts already included in the FY 2017 baseline. These funds would be used to help the Veterans Health Administration deal with the continuing growth in ensuring coverage for gynecological, prenatal, and obstetric care, other gender-specific services, and for maintenance and repair of facilities hosting women's care to improve privacy and safety of these facilities. The new funds would also aid VHA in making its cultural transformation to embrace women veterans and welcome them to VA health care services, and provide means for VA to improve specialized mental health and readjustment services for women veterans.

Spinal Cord Injury/Disease Care

The IBVSOs remain concerned that adequate resources are not being directed towards the VA's largest inpatient system of care. The Spinal Cord Injury & Disease (SCI/D) continuum of care model for the lifetime treatment of veterans with SCI/D has evolved over a period of more than 50 years. VA SCI/D care has been established in a unique "Hub and Spokes" model. If SCI/D centers are underfunded, and thus insufficiently staffed, spoke facilities (often secondary VA medical centers) are forced to care for veterans in need of types of complex, acute care that they are unprepared to provide. Like private sector non-specialized care, care at spoke facilities is insufficient to treat SCI/D-specific acute conditions (e.g. pressure ulcer debridement, complex urinary tract infection) because the spokes are only equipped to provide basic primary and preventative health care. Both Congress and VA must work together to ensure all VA SCI/D Centers have the right number of available operating beds and nurse staffing ratios to care for referred veterans, and revisit annual reporting requirements to measure capacity for VA SCI/D and other specialized care as previously required by Public Law 104-262.

Advance Appropriations for FY 2018

FY 2018 IB Advance Appropriations Recommendation	\$64.0 billion
FY 2018 Administration Advance Appropriations Request	
Medical Services	\$44.9 billion
Medical Community Care (New Proposed Account in FY17)	\$9.4 billion
Medical Care Collections	\$3.6 billion
Subtotal	\$57.9 billion

The Independent Budget once again offers baseline projections for funding through advance appropriations for the Medical Care accounts for FY 2018. While the enactment of advance appropriations for VA medical care in 2009 helped to improve the predictability of funding requested by the Administration and approved by Congress, we have become increasingly concerned that sufficient corrections have not been made in recent years to adjust for new, unexpected demand for care.

For FY 2018, The Independent Budget recommends approximately \$64.0 billion for Medical Services. Our Medical Services level includes the following recommendations:

Current Services Estimate.....\$61,011,026,000
 Increase in Patient Workload.....\$1,351,883,000
 Additional Medical Care Program Cost.....\$1,670,000,000
 Total FY 2017 Medical Services.....\$64,032,909,000

Our estimate of growth in patient workload is based on a projected increase of approximately 93,000 new patients. These new unique patients include priority group 1≥-8 veterans and covered nonveterans. We estimate the cost of these new patients to be approximately \$1.1 billion. This recommendation also reflects an assumption that more veterans will be accessing the system as VA expands its capacity and services and we believe that reliance rates will increase as veterans examine their health care options as a part of the Choice program. The increase in patient workload also assumes a projected increase of 49,500 new OEF/OIF and OND veterans, at a cost of approximately \$207 million.

Last, as previously discussed, the IBVSOs believe that there are additional medical program funding needs for VA. The Independent Budget recommends \$285 million directed toward VA long-term-care programs. In order to continue to provide the critically needed Hepatitis C treatments, we recommend \$1 billion to treat 30,000 veterans. In order to meet the increase in demand for prosthetics, the IB recommends an additional \$160 million. Our additional program cost recommendation includes continued investment of \$125 million in the Comprehensive Family Care-giver program. Finally, we believe that VA should invest a minimum of \$100 million as an advance appropriation in FY 2018 to expand and improve access to women veterans' health care programs.

Medical Support and Compliance

FY 2017 IB Recommendation	\$6.223 billion
FY 2017 Enacted Advance Appropriations	\$6.524 billion
FY 2017 Revised Administration Request	\$6.524 billion
FY 2018 IB Advance Appropriations Recommendation	\$6.314 billion
FY 2018 Administration Advance Appropriations Request	\$6.654 billion

For Medical Support and Compliance, The Independent Budget recommends \$6.2 billion for FY 2017. Our projected increase reflects growth in current services based on the impact of inflation on the FY 2016 appropriated level. Additionally, for FY 2018 The Independent Budget recommends \$6.3 billion for Medical Support and Compliance. This amount also reflects an increase in current services from the FY 2017 advance appropriations level.

Medical Facilities

FY 2017 IB Recommendation	\$5.742 billion
FY 2017 Enacted Advance Appropriations	\$5.074 billion
FY 2017 Revised Administration Request	\$5.723 billion
FY 2018 IB Advance Appropriations Recommendation	\$6.684 billion
FY 2018 Administration Advance Appropriations Request	\$5.435 billion

For Medical Facilities, The Independent Budget recommends \$5.7 billion for FY 2017, nearly \$700 million more than the enacted advance appropriation from December 2015. Our Medical Facilities recommendation includes \$1.35 billion for Non-Recurring Maintenance (NRM). The Administration's request over the past two budget cycles represented a wholly inadequate level for NRM funding, particularly in light of the actual expenditures that were outlined in the budget justification. While VA has actually spent on average approximately \$1.3 billion yearly for NRM, the Administration has requested only \$460 million for NRM. This request level is clearly insufficient. This decision means that VA is forced to divert funds pro-

grammed for other purposes to meet this need. Additionally, our recommendation includes \$692 million for operating and capital leases.

The Independent Budget recommends approximately \$6.7 billion for Medical Facilities for FY 2018. Our FY 2018 advance appropriation recommendation also includes \$1.35 billion for NRM. Last year the Administration's recommendation for NRM reflected a projection that would place the long-term viability of the health care system in serious jeopardy. This deficit must be addressed.

Medical and Prosthetic Research

FY 2017 IB Recommendation	\$665 million
<i>Million Veteran Program</i>	\$75 million
Total IB Medical and Prosthetic Research	\$740 million
FY 2016 Enacted Final Appropriation	\$631 million
FY 2017 Administration Request	\$663 million

The VA Medical and Prosthetic Research program is widely acknowledged as a success on many levels, and contributes directly to improved care for veterans and an elevated standard of care for all Americans. The research program is an important tool in VA's recruitment and retention of health care professionals and clinician-scientists to serve our nation's veterans. By fostering a spirit of research and innovation within the VA medical care system, the VA research program ensures that our veterans are provided state-of-the-art medical care.

Investing Taxpayers' Dollars Wisely

Despite documented success of VA investigators across many fields, the amount of appropriated funding for VA research since FY 2010 has lagged far behind annual biomedical research inflation rates, resulting in a net loss over these years of nearly 10 percent of the program's overall purchasing power. As estimated by the Department of Commerce, Bureau of Economic Analysis, and the National Institutes of Health, for VA research to maintain current service levels, the Medical and Prosthetic Research appropriation should be increased in FY 2017 by 2.7 percent over the FY 2016 baseline simply to keep pace with inflation. With this in mind, The Independent Budget recommends approximately \$17 million to meet current services demands for research.

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

Emerging Research Needs

In addition to covering uncontrollable inflation, the IBVSOs believe Congress should appropriate an additional \$17 million for FY 2017, for expanding research on emerging conditions prevalent among newer veterans, as well as continuing VA's inquiries in chronic conditions of aging veterans from previous wartime periods. For example, additional funding will help VA support areas that remain critically underfunded, including:

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

Million Veteran Program

The VA Research program is uniquely positioned to advance genomic medicine through the “Million Veteran Program” (MVP), an effort that seeks to collect genetic samples and general health information from 1 million veterans over the next five years. When completed, the MVP will constitute one of the largest genetic repositories in existence, offering tremendous potential to study the health of veterans. To date, more than 400,000 veterans have enrolled in MVP. The VA estimates it currently costs around \$75 to sequence each veteran’s blood sample. Under the President’s Precision Medicine Initiative, the IBVSOs recommend \$75 million to enable VA to process one quarter of the MVP samples collected.

General Operating Expenses (GOE)

Veterans Benefits Administration

FY 2017 IB Recommendation	\$3.056 billion
FY 2016 Enacted Final Appropriation	\$2.708 billion
FY 2017 Administration Request	\$2.826 billion

The Veterans Benefits Administration (VBA) account is comprised of six primary divisions. These include Compensation; Pension; Education; Vocational Rehabilitation and Employment (VR&E); Housing; and Insurance. The increases recommended for these accounts primarily reflect current services estimates with the impact of inflation representing the grounds for the increase. However, two of the subaccounts—Compensation and VR&E—also reflect a substantial increase in requested staffing.

The IB recommends approximately \$3.056 billion for the VBA for FY 2017. This amount reflects an increase of approximately \$348 million over the recently enacted FY 2016 appropriations level. Our recommendation includes approximately \$171 million in additional funds in the Compensation account above current services, and approximately \$17.6 million more in the VR&E account above current services, and provide for new full-time equivalent employees (FTEE).

Compensation Service Personnel 1,700 New FTEs\$171 million

Over the past few years, VBA has made significant progress in reducing the disability compensation backlog, which stood at over 600,000 claims in March 2013, to just over 77,000 in January 2016; this represents nearly an 87 percent reduction in the backlog in just under three years’ time. In 2009, VBA issued decisions on 2.74 million medical issues; that number more than doubled to 6.35 million in FY 2015. Today, VBA reports that on average, 92 days are required to process a claim; in March of 2013, VBA required roughly 282 days.

Some of VBA’s claims processing progress can be attributed to the development and deployment of a new organizational model and new information technology (IT) systems, including the Veterans Benefits Management System (VBMS), e-Benefits, and the Stakeholder Enterprise Portal (SEP). However, much of the increased productivity is the result of simply putting more resources into processing claims, specifically, the use of mandatory overtime. What remains unknown is whether VBA will be able to manage its current claims inventory of 352,000 claims, without needing to rely on mandatory overtime.

Recognizing that rising workload, particularly claims for disability compensation, could not be addressed without additional personnel, Congress provided VBA with more than 1,000 FTEs between FY 2013 and FY 2016, primarily in Compensation Service. In FY 2016 alone, Congress authorized VBA to hire an additional 770 FTEE. The new FTEE were to be purposed for non-rating activities. However, taking into consideration VBA’s total workload, including appeals, these increases in personnel have not been sufficient to keep pace with incoming workload or to reduce the backlogs in these non-rating areas.

A blend of technology and people will be required to enable VBA to provide veterans and their dependents with more timely and accurate decisions. Necessary personnel increases should not be tempered against a hoped-for future technological capability. Although VBA’s new claims processing systems have the potential to transform the delivery and accuracy of benefits, its full effect may not be realized for years.

As a consequence of this concentrated effort to reduce the claims backlog, the backlogs for other activities, including appeals, have grown. As of February 2016, 440,000 appeals were pending, 360,000 within the jurisdiction of the VBA and the remainder within the jurisdiction of the Board of Veterans Appeals. This growing

appeals backlog is a result of VBA's shift in focus and resources to process disability claims, as evidenced by the fact that Decision Review Officers (DROs) and Quality Review Specialists (QRSs) were performing development and rating duties during both regular and overtime working hours at many VA regional offices (VARO).

Considering the enormous growth in appeals, non-rating activities and other services, the IBVSOs believe that more accurate staffing and production models are required to determine future resources for VBA.

For FY 2017, the IBVSOs will focus resource recommendations on VBA's non-rating related work, appeals processing, and call center needs. We recommend an additional 1,000 FTEE for FY 2017 that would be dedicated to processing appeals at VBA in an effort to eliminate the backlog of 360,000 appeals within the next three years. Depending on the progress made over the next year, further personnel increases may still be necessary to address this appeals backlog.

To address the growing backlog of non-rating related work such as dependency claims, the IBVSOs recommend an additional 300 FTEE. In order to address the delays experienced by callers contacting VBA call centers, the IBVSOs recommend an additional 300 FTEE.

In addition, the IBVSOs recommend an increase of 100 FTEE for the Fiduciary program to meet the growing needs of veterans participating in VA's Caregiver Support programs. This recommendation is also based on a July 2015 VA Inspector General report on the Fiduciary program that found, "Field Examiner staffing did not keep pace with the growth in the beneficiary population, [and] VBA did not staff the hubs according to their staffing plan."

Since VA may achieve future technological and organizational productivity gains, we recommend that VBA hire a blend of permanent and two-year temporary FTEEs to fill all new positions. At the end of the two years, the best of those hired on a temporary basis could be transitioned into permanent positions made available through attrition. The IBVSOs believe this approach to staffing would offer a temporary surge capacity, while also developing a group of experienced and trained employees to fill positions that occur through attrition.

VR&E Service Personnel 158 New FTEEs \$17.6 million

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

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

These additional functions of VR&E personnel are undoubtedly beneficial to disabled veterans; however, staffing levels throughout VR&E services must be commensurate with current and future demands and their global responsibilities.

At the end of FY 2014, VR&E reported a total of 1,416 FTEEs dedicated to direct VR&E services. VR&E projected an increase of 7.3 percent in program participation for FY 2015, and for FY 2016 an additional 3.8 percent increase in participation was expected. Over the previous two fiscal years, program participation was expected to increase by 11.1 percent; however, the Administration failed to request adequate staffing levels to keep pace with anticipated demand. In fact for FY 2015 and FY 2016, only 1,442 direct personnel were requested, with no increase for FY 2016.

Over the past five years, program participation has increased by an average of 7.1 percent each year, and the IBVSOs project that total program participation for FY 2017 will grow by at least 7.1 percent for total caseload of approximately 147,000. In July 2015, VR&E reported that its average Vocational Rehabilitation Counselor (VRC)-to-client ratio was 1:139, which represented an increase from its previous 1:135 ratio. A more reasonable VRC-to-client ratio would consist of 1:125; however, this benchmark may even be too high when taking into consideration the overall responsibilities of VRCs, such as VSOC and IDES.

In order to achieve and sustain a 1:125 counselor -to-client ratio in FY 2017, we estimate that VR&E would need 158 new FTEE, for a total workforce of 1,600 FTEE, to manage an active caseload of 147,000 VR&E participants. At a minimum, three-quarters of the new hires should be VRCs dedicated to providing direct services to veterans.

While increased staffing levels are required to provide efficient and timely services to veterans utilizing VR&E services, it is also essential that these increases be

properly distributed throughout all of VR&E to ensure that VRC caseloads are equitably balanced among VAROs, which typically experience variable caseloads. As an example, a January 2014 GAO Report found the Cleveland VARO's VRC ratio to be 1:206 and in the Fargo VARO, the ratio was 1:64.

General Administration

FY 2017 IB Recommendation	\$346 million
FY 2016 Enacted Final Appropriation	\$337 million
FY 2017 Administration Request	\$417 million

The General Administration account is comprised of nine primary divisions. These include the Office of the Secretary; the Office of the General Counsel; the Office of Management; the Office of Human Resources and Administration; the Office of Policy and Planning; the Office of Operations, Security and Preparedness; the Office of Public and Intergovernmental Affairs; the Office of Congressional and Legislative Affairs; and the Office of Acquisition, Logistics, and Construction. For FY 2017, the IB recommends approximately \$346 million, an increase of nearly \$9.0 million over the FY 2016 appropriated level. This increase reflects only an increase in current services based on the impact of uncontrollable inflation across all of the General Administration accounts.

Board of Veterans' Appeals

FY 2017 IB Recommendation	\$134 million
FY 2016 Enacted Final Appropriation	\$110 million
FY 2017 Administration Request	\$156 million

Board of Veterans' Appeals Personnel 166 New FTEEs \$23.1 million

Faced with a growing number of claims and resultant appeals, the Board's staff grew from 510 FTEE in FY 2012 to 676 FTEE in FY 2015. For 2016, the Administration did not request funding for increased staffing, despite an ever increasing workload; instead the FY 2016 budget proposed a reduction from of 669 FTEE to 662 FTEE.

Over the past few years, the Board has averaged approximately 90 appeal dispositions per FTEE, producing a record 55,532 decisions in FY 2014. Current data was not available at the time of this report; however, we estimate that for FY 2015 the Board issued nearly 60,000 dispositions. Although most of the 440,000 pending appeals are in various stages of processing at VBA, the Board currently has nearly 80,000 appeals in its jurisdiction. In order to process these 80,000 appeals in one year, based on 90 appeals per Board FTEE, the Board would need approximately 890 FTEE; however, it did not receive any increase for FY 2016, and will likely only be able to again dispose of approximately 60,000 appeals.

Furthermore, as the number of claims processed annually continues to rise as a result of the increased capacity of VBA, the number of appeals is also expected to continue rising. Even with increased accuracy in rating board decisions, on average 10 to 12 percent of claims decisions are appealed. Thus, assuming VBA processes 1.5 million claims next year—a reasonable estimate considering VBA processed over 1.4 million claims in both FY 2014 and FY 2015—roughly 150,000 appeals would enter the system, with roughly half of them continuing on to the Board for appellate review. In order for the Board to keep pace with only this new incoming workload and not those appeals already in the system, a total FTEE level of 833 would be required. Furthermore, a significant number of Board remands return to the Board for another round of appellate review, as many as 20,000 per year, requiring an additional 217 FTEE to manage that workload.

About 360,000 appeals are backlogged at VBA, of which approximately 180,000 are expected eventually to reach the Board. If the goal were to eliminate the backlog in three years, while simultaneously disposing of both new incoming appeals and returning remanded appeals, then an additional 666 FTEE would be required. In total, without any increases in productivity, the Board would require 1,716 FTEE,

almost tripling its current workforce. Even if the Board could increase its productivity by one-third to 120 appeals per FTEE, approximately 1,291 FTEE, almost double the current workforce, would be needed.

To meet current and future workload requirements, the Board will need to continue adding new attorneys and veteran law judges, as well as sufficient support staff; however, the Board could not absorb that level of staffing growth while simultaneously managing its overall workload. Approximately 18 months of training and orientation are required for a new Board attorney to reach full productivity. Given the time taken away from existing staff to train and mentor new staff, the Board must strike a balance in its hiring strategy.

For FY 2017, the IBVSOs recommend an increase 166 FTEE for FY 2017, a 25 percent increase, bringing the Board's total FTEE to 828. The Board must expect to increase its personnel over the next couple of years to continue to grow its capacity to handle the rising number of appeals that will come from VBA's increased productivity.

Another option the Board may want to consider in future years would be to authorize a mix of full-time and temporary hires, utilizing the temporary workforce in a "surge-capacity" role to help reduce the appeals backlog.

Departmental Administration and Miscellaneous Programs

Information Technology

FY 2017 IB Recommendation	\$4.209 billion
FY 2016 Enacted Final Appropriation	\$4.133 billion
FY 2017 Administration Request	\$4.278 billion

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

For FY 2017, the IBVSOs recommend approximately \$4.2 billion for the administration of the VA's IT program. This recommendation includes no new funding above the planned current services level. Significant resources have already been invested in VA's IT programs in recent years, and we believe proper allocation of existing resources can allow VA to fulfill its missions while modernizing its systems. We continue to call for acceleration of the VBMS, and the implementation of an appropriate solution for the Board of Veterans Appeals IT system.

Additionally, it is critical to ensure that sufficient funds are directed at the incremental costs of implementation for the new Veterans Choice Program (VCP). The VA identified a series of one time incremental costs for IT systems in order to redesign, develop, and deliver systems and technology solutions for the new VCP. Those incremental costs range from \$421 million in Phase I of the project, to \$606 million in Phase II, and finally \$851 million in Phase III. Without having a clear plan for when each of these Phases might actually take place, The Independent Budget has chosen not to explicitly recommend these funds in our IT funding recommendation. However, we believe Congress must consider these costs in an effort to assist the VA in implementing the new VCP.

National Cemetery Administration

FY 2017 IB Recommendation	\$275 million
FY 2016 Enacted Final Appropriation	\$271 million
FY 2017 Administration Request	\$286 million

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

In a strategic effort to meet the burial and access needs of our veterans and eligible family members, the NCA continues to expand and improve the national cemetery system, by adding new and/or expanded national cemeteries. Not surprising, due to the opening of additional national cemeteries, the NCA is expecting an increase in the number of annual veteran interments through 2017 to roughly 130,000, up from 125,180 in 2014; this number is expected to slowly decrease to 126,000 by 2020. This much need expansion of the national cemetery system will help to facilitate the projected increase in annual veteran interments and will simultaneously increase the overall number of graves being maintained by the NCA to 3.7 million in 2018 and 3.9 million by 2020.

Even as the NCA continues to add veteran burial space to its expanding system, many existing cemeteries are exhausting their capacity and will no longer be able to inter casketed or cremated remains. In fact, as of 2016, the NCA expects four national cemeteries-Baltimore, Maryland; Nashville, Tennessee; Danville, Virginia; and Alexandria, Virginia-to reach their maximum capacity and will be closed to first interments, though they will continue to accept second interments.

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

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

Additional areas of growth within the NCA system include:

- An increase in the issuance of Presidential Memorial Certificates, which is expected to increase from approximately 654,000 in 2013 to more than 870,000 in 2017;
- The expected increase in the burial of Native American, Alaska Native, and Pacific Islander veterans; and
- The possible increase, thanks to local historians and other interested stakeholders, in requests for headstones or markers for previously unidentified veterans.

Budgetary Resources for NCA Programs

With the above considerations in mind, The Independent Budget recommends \$275 million for FY 2017 for the Operations & Maintenance of the NCA. The IBVSOs believe that this should include a minimum of \$20 million for the National Shrine Initiative. Since FY 2013, national shrine funding has decreased each year. The NCA must continue to invest sufficient resources in the National Shrine Initiative to ensure that this important work is completed.

Office of the Inspector General

FY 2017 IB Recommendation	\$138 million
FY 2016 Enacted Final Appropriation	\$137 million
FY 2017 Administration Request	\$160 million

The Office of Inspector General (OIG) received a significant infusion of new resources for FY 2016 due to the high volume of work that it has produced. And yet, the OIG has been under significant scrutiny over the past year. We believe that the work requirements assigned to this office have placed it under great stress and potentially stretched it beyond its capacity. That being said, the IBVSOs believe that the office does not warrant a staffing increase at this time. We believe that the substantial increase that the OIG received in FY 2016 should allow it to expand its staffing sufficiently to meet the ever-growing demands on its work. With this in mind, the IB recommends funding based on current services of approximately \$138 million.

Construction Programs

Major Construction

FY 2017 IB Recommendation	\$1.50 billion
FY 2016 Enacted Final Appropriation	\$1.24 billion
FY 2017 Administration Request	\$528 million

Each year the Department of Veterans Affairs outlines its current and future major construction needs in its annual Strategic Capital Investment Planning (SCIP) process. In its FY 2016 budget submission, VA projected it would take between \$11.2 billion and \$13.6 billion to close all current and projected gaps in access, utilization, and safety. Currently, VA has more than 30 major construction projects that are either partially funded or funded through completion, but in which construction is incomplete.

Last year VA requested and Congress appropriated a significant increase in funding for major construction projects—approximately \$1.24 billion. While these funds will allow VA to begin construction on key projects, many other previously funded sites still lack the funding for completion. One of these projects was originally funded in FY 2007, while others were funded more than five years ago but no funds have been spent on the projects to date. Of the 33 projects on VA's partially funded VHA construction list, nine are seismic in nature.

It is time for the projects that have been in limbo for years or that present a safety risk to veterans and employees to be put on a course to completion within the next five years. To accomplish this, the IBVSOs recommend that Congress appropriate \$1.5 billion for FY 2017 to fund either the next phase or fund through completion all existing projects, and begin advance planning and design development on six major construction projects that are the highest ranked on VA's priority list.

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

Research Infrastructure

State-of-the-art research requires state-of-the-art technology, equipment, and facilities. For decades, VA construction and maintenance appropriations have not provided the resources VA needed to maintain, upgrade, or replace its aging research laboratories and associated facilities. The impact of funding shortages was vividly demonstrated in a Congressionally-mandated report that found major, system wide deficits in VA research infrastructure. Nearly 40 percent of the deficiencies found were designated "Priority 1: Immediate needs, including corrective action to return components to normal service or operation; stop accelerated deterioration; replace items that are at or beyond their useful life; and/or correct life safety hazards."

The report cited above estimated that approximately \$774 million would be needed to correct all deficiencies found, but only a fraction of that funding has been appropriated since this report was made public in 2012. The VA Office of Research and Development is conducting a follow-up study of over a dozen key research sites. This update should be available in mid-2016, the results of which can be used to guide VA and Congress in further investment in VA research infrastructure. Nevertheless, Congress needs to begin now to correct the most urgent of these known infrastructure deficiencies, especially those that concern life-safety hazards for VA scientists and staff, and for veterans who volunteer as research subjects.

The IBVSOs believe that Congress should break this chronic stalemate and designate funds to improve specific VA research facilities in FY 2017 and in subsequent years. In order to begin to address these known deficits, the IBVSOs recommend Congress approve at least \$50 million for up to five major construction projects in VA research facilities.

The full report discussed above is available at www.aamc.org/varpt. The House reports associated with this issue are House Report 109–95, and House Report 111–559.

Minor Construction

FY 2017 IB Recommendation	\$749 million
FY 2016 Enacted Final Appropriation	\$406 million
FY 2017 Administration Request	\$372 million

In FY 2016, Congress appropriated \$406 million for minor construction projects. Currently, approximately 600 minor construction projects need funding to close all current and future year gaps within the next 10 years. To complete all of these current and projected projects, VA will need to invest between \$6.7 and \$8.2 billion over the next decade.

In August 2014, the President signed the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 133–146. In this law Congress provided \$5 billion to increase health care access by increasing medical staffing levels and investing in infrastructure using these funds. VA has developed a spending plan that will obligate \$511 million for 64 minor construction projects over a two-year period.

VA planned to invest \$383 million of these funds in FY 2015, leaving \$128 million for minor projects in FY 2016. It is important to remember that these funds are a supplement to, not a replacement of, annual appropriations for minor construction projects. To ensure that VA funding keeps pace with all current and future minor construction needs, the IBVSOs recommend that Congress appropriate an additional \$749 million for minor construction projects.

Additionally, the IBVSOs recommend \$175 million in non-recurring maintenance and minor construction funding to address needs of facilities identified in the Congressionally-requested report on the status of VA research facilities discussed earlier in this report.

Grants for State Extended-Care Facilities

(State Home Construction Grants)

FY 2017 IB Recommendation	\$200 million
FY 2016 Enacted Final Appropriation	\$120 million
FY 2017 Administration Request	\$80 million

Grants for state extend-care facilities, commonly known as state home construction grants, are a critical element of federal support for the state veterans' homes. The state home program is a very successful federal-state partnership in which VA and states share the cost of constructing and operating nursing homes and domiciliaries for America's veterans. State homes provide over 30,000 nursing home and domiciliary beds for veterans, their spouses, and gold-star parents of deceased veterans. Overall, state homes provide more than half of VA's long-term-care workload, but receive less than 15 percent of VA's long-term-care budget. VA's basic per diem payment for skilled nursing care in state homes is significantly less than comparable costs for operating VA's own long-term-care facilities. This basic per diem paid to state homes covers approximately 30 percent of the cost of care, with states responsible for the balance, utilizing both state funding and other sources. On average, the daily cost of care for a veteran at a State Home is less than 50 percent of the cost of care at a VA long-term-care facility.

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

In FY 2016, the estimated federal share for the 109 state home construction grants requests that have been submitted by states was over \$1 billion. Of that amount, the states had already secured their state matching funds required to put them in the Priority Group List 1 for 69 projects that will require \$550 million in

federal matching funds. Last year, VA requested only \$85 million and the IBVSOs had recommended \$200 million; Congress ultimately appropriated \$120 million funding for FY 2016, which will fund only the first 13 projects on the FY 2016 Priority Group 1 List.

With almost \$1 billion in state home projects still in the pipeline, the IBVSOs again recommend \$200 million for the state home construction grant program, which we estimate would provide funding for approximately 40 percent of the projects expected to be on the FY 2017 VA Priority Group 1 List when it is released at the end of this year.

Grants for State Veterans Cemeteries

FY 2017 IB Recommendation	\$52 million
FY 2016 Enacted Final Appropriation	\$46 million
FY 2017 Administration Request	\$45 million

The State Cemetery Grant Program allows states to expand veteran burial options by raising half the funds needed to build and begin operation of veterans' cemeteries. The NCA provides the remaining funding for construction and operational funds, as well as cemetery design assistance. As of September 2014, there were 49 projects with state matching funds.

Funding eight projects in FY 2017 will provide burial options for an additional 148,000 veterans. To fund these projects, Congress must appropriate \$52 million.

THE AMERICAN LEGION

"What we have done historically is that we have managed to a budget number as opposed to managing to requirements as a result we've muddled along and not met the needs veterans deserve."

- VA Acting Secretary Sloan Gibson before the House Committee on Veterans Affairs July 24, 2014¹

When now Deputy Secretary of the Department of Veterans Affairs (VA) Sloan Gibson addressed this committee nearly two years ago, he was not advocating the budgetary planning approach he described, but speaking to the problems that long standing approach could cause. Drawing contrasts with the planning models he was familiar with in the private sector, Deputy Secretary Gibson noted the historical approach was about managing to requirements. For VA to succeed and be great, they need to be able to move beyond managing requirements and move towards building planning based on need.

Chairman Miller, Ranking Member Brown, and Members of the Committee:

On behalf of National Commander Dale Barnett and the over million members of The American Legion, we welcome this opportunity to comment on the federal budget, and programs of the Department of Veterans Affairs (VA).

The American Legion is a resolution based organization; we are directed and driven by the millions of active legionnaires who have dedicated their money, time, and resources to the continued service of veterans and their families. Our positions are guided by nearly 100 years of consistent advocacy and resolutions that originate at the grassroots level of the organization - the local American Legion posts and veterans in every congressional district of America. The Headquarters staff of the Legion works daily on behalf of veterans, military personnel and our communities through roughly 20 national programs, and hundreds of outreach programs led by our posts across the country.

What we present here is an attempt to focus on a few particular issues and projected needs, rather than what has been the historical and problematic approach of presenting a budget based on a number. While the budget numbers have gone up for VA, indicative of the commitment that Congress has shown even in tight fiscal times, there has still been the tendency to set an number and manage to that limit, rather than projecting the need and divining numbers from that need.

In terms of future planning, and ensuring that VA's budget meets needs in critical areas, The American Legion directs the committee's focus to three critical areas: the

¹ HVAC Hearing "Restoring Trust: The View of the Acting Secretary and the Veterans Community" - July 24, 2014

consolidation of outside care, ensuring VA's medical hiring needs are met, and addressing the rising backlog of appeals.

Consolidation of Outside Care:

When the Choice Card program was added as a temporary emergency measure as a part of the Veterans Access, Choice and Accountability Act (VACAA) of 2014² The American Legion supported the program because we had seen firsthand the need across the country. During 2014 The American Legion set up a dozen Veterans Crisis Command Centers (VCCCs) in affected areas from Phoenix to Fayetteville and spoke to hundreds of veterans personally affected by the scheduling problems within VA. The Choice Card program provided an immediate short term option, but also provided an opportunity to learn from how veterans utilized the program. At the time, The American Legion advised gathering as much data as possible from veterans' use of the program to make all of VA's other existing authorities for care in the community³ better in their ability to serve veterans.

Ultimately that has led to the current transformation in VA's community care programs. As directed by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act) in July 2015, VA has developed a plan to consolidate all existing programs into a single community care program, the New Veterans Choice Program (New VCP). Generally, The American Legion supports the plan to consolidate VA's multiple and disparate purchased care programs into one New VCP. We believe it has the potential to improve and expand veterans' access to health care. Much depends, however, on the department's success in working with its employees, Congress, VSOs, private providers, academic affiliates, and other stakeholders as the agency moves forward in developing and implementing the plan.

However, with an eye towards budgetary matters, there are two important considerations revolving around this new transformation that must be implemented in future budgets. VA must have the ability to spend all community care monies under the new framework, and the additional funding required to provide for the Choice Card program needs to be factored into future budgets.

During 2015, VA ran into problems with budgetary shortfalls because of the separation in funding between Choice Card care and other community care authorities. Because of the strong push to ensure veterans were seen as quickly as possible, VA quickly exhausted care in the community funding, while emergency funding for the Choice Card program was still available. VA was forced to seek, and was granted, authority to move some of the \$10 billion allocated to fund the Choice Card program over the three year pilot to cover care in the community costs.

By now, as the transformation of care in the community moves forward to a plan with a single, overarching authority for this care (New VCP) the distinctions between the VACAA Choice funds and community care funding should be academic. While The American Legion understands there are reasons certain funding and accounts have limitations, and is not advocating for a wholesale removal of barriers for VA to move funding, in this instance it makes perfect logical sense. Care in the community is care in the community, and VA must have a single stream of funding for this.

However, it is equally important that the need for the extra funding was and is real. The VACAA provided \$10 billion for treating veterans in the community through Choice because the need to fund that care was real. Those needs are not going away. As of last month, VA had over 6.1 million appointments scheduled nationwide, and over 8.5% of those appointments are still waiting over 30 days for treatment.⁴ VA has seen their number of completed appointments jump by over 2.6 million last year, and they are throughout his continuing to authorize millions of appointments for outside care.

The \$10 billion from VACAA was provided as emergency funding, but in the future, we must plan for the tremendous demand on the VA system. This is a direct illustration of the managing to numbers versus managing to need contrast mentioned above. For future budgets, we must ensure that VA is receiving funding for care that adequately reflects how they must deliver that care. A robust budget for VA medical care is necessary, but as the past few years have shown VA has been dependent as well on care in the community to provide timely care to veterans where they are overburdened by scheduling, staffing, or lack of appropriate re-

²Public Law P.L. 113-146

³Such as Project Access Received Closer to Home (ARCH), the Patient Centered Community Care (PCs) program and others

⁴VA Pending Appointments - January 15, 2016

sources in the community. This needs to be reflected in the community care budgets, not as an emergency measure when the problem boils over and out of control.

Ensuring Proper VA Staffing:

One reason VA may sometimes struggle to provide care within the Veterans Health Administration (VHA) is directly related to staffing. The staffing figures can be ugly. One in six positions nationally for some critical jobs remain vacant, and critical needs like psychiatric workers can see vacancy rates of 40–64%.⁵

To be fair, the VACAA already provided funding for 10,000 new health care positions, however funding new positions alone may not be the solution and there may be budgetary means to address some of the vacancies. Even when VA is hiring an additional 9% of their workforce they are losing a similar amount to attrition.⁶ Some of this could be improved with better hiring incentives and more competitive wages, particularly in key fields of need such as psychiatric care, physician's assistants, nurses and physical therapists.

To be sure, as the Office of the Inspector General recommended, VA also bears additional responsibility in the form of the development of better staffing models and examining the red tape and bureaucratic burdens that stretch hiring out into a process that can take nine months or longer.⁷ However, additional examination of where VA can better incentivize prospective applicants to decide on a career serving veterans would be helpful. We need to ensure VA has proper funding to get the best and brightest team members on their medical and psychological staffs serving veterans.

The VA can further help improve their staffing, especially in leadership positions, with better succession planning for VA employees to rise to leadership levels within the organization. As an organization of advocates that has worked hand in hand with VA for decades, The American Legion notes the training programs VA had in place during the 1990's were better suited to creating the next generation of leadership than the current programs in place. The VHA training programs of the 1990's were specifically built to prepare administrative employees to assume mid-level management programs at the department level. This could include personnel, fiscal, medical administration, associate director training and other leadership training. The programs were replaced, over time, with VA's current Leadership Development Programs, but feedback The American Legion has garnered from interacting with VHA personnel during visits from our System Worth Saving Task Force has indicated these programs are not providing the tools the employees need to be the next generation leaders of VA and to lead from within. Additional consideration to re-vamping this portion of training, and ensuring this training is properly funded, could be a key component to reducing VA's reliance on the complicated process of hiring from outside VA and ultimately reduce the number of unfilled leadership positions.

The Looming Appeals Crisis:

Last year, 2015, was the year VA was supposed to “break the back of the backlog” of veterans' claims for disability benefits. While VA has made substantial progress according to their public figures in reducing the number of initial claims - the “claims backlog” sits at around 77,000 claims today⁸ down from a peak of over 600,000 claims in early 2013 - those numbers do not reflect the waiting period for many veterans who have been waiting for three or more years for their appeals to be decided. Over that same period the number of appeals has soared to over 325,000 from their level of 250,000 in 2013.⁹ VA defines “backlog” as any case pending over 125 days. Every single appeal represents a veteran who has been waiting for much, much longer than 125 days, but those 325,000 appeals are not counted as part of the “backlog.”

Often the fastest way to resolve an appeal is with a Decision Review Officer (DRO) in a Regional Office (VARO). The DROs are among the most experienced employees, and can discern aspects of a claim that a newer employee might miss, furthermore after an initial denial the veteran can be better equipped to provide information the VA noted was lacking in the initial denial. Because everything stays within the VARO, correspondence with the veteran and with a service officer helping that veteran is direct and many claims can be resolved more quickly through

⁵ USA Today - September 2015

⁶ VA Office of the Inspector General (VAOIG) Report No. 15-03063-511 “OIG Determination of Veterans Health Administration's Occupational Staffing Shortages” - September 2015

⁷ Ibid

⁸ VA Claims Backlog Dashboard - January 30, 2016

⁹ VA Monday Morning Workload Report - February 1, 2016

this process. The DRO review can be one of the best tools for speedy adjudication of an appeal and to reduce the appeals backlog. However, the unfortunate case recently is that DROs have not always been free to handle their appeals workload.

The Veterans Benefits Administration (VBA) has been under a singular mission to reduce the backlog. To this end they have forced over four years of mandatory overtime, and key veteran staffers including DROs have seen their workloads adjusted to focus on the initial claims, the claims that are counted in the VA statistics for “backlog.” This can have the effect of keeping DROs from devoting full attention to their appeals workload, and the growing appeals backlog cannot be seen as an accident.

Last year, The American Legion noted that occasional mandatory overtime in a short term crisis is prudent management, but four straight years is indicative of an organization that’s clearly understaffed. The American Legion reiterates our call for better study of VBA staffing models, but also notes that last year VA had proposed making the DRO process more robust, something we wholeheartedly support.

“DROs can often resolve appeals more rapidly than the appeal process at the Board of Veterans Appeals (BVA) and with greater accuracy and clarity than the average VA rater. Reports have indicated in some offices the DROs have been reassigned to other tasks as the pressure mounts to work on initial claims. It would be the hope of The American Legion that renewed interest in hiring and increasing the DRO force would allow DROs to return to their appeals duties, and help prevent a rising backlog in the appeals area.”¹⁰

There have been many recent proposals for measures to transform appeals as the initial claims process was transformed by the Veterans Benefits Management System (VBMS) and the Fully Developed Claims (FDC) process. The American Legion is supportive of transformative thinking, clearly the system as it has existed in the past has many flaws and has not always served veterans with the ability to develop prompt and accurate decisions on disability claims. However, it is also critical to understand that there is important due process in the system to protect veterans, and we cannot abandon these things in the interest of simply faster decisions or more convenience for VA.

Due process is important to protect veterans, especially veterans who may be uniquely vulnerable due to their disabilities incurred in the service of this nation. It is one of the reasons the veterans’ disability claims system has been specifically cited as “uniquely pro-claimant” in the manner it serves veterans filing for benefits.¹¹ Veterans need to depend on the ability to get a DRO review in a timely fashion, or to submit evidence in response to the VA when they are informed their claim is lacking proof of a key point, such as documentation of an event that happened in service.

One of the best things to help address the growing appeals backlog would be to increase funding for DROs to fully staff all offices and to add additional full time employees elsewhere within the offices to get the DROs back to doing what they do best, reviewing appeals in a timely manner. The budget should also reflect additional funding to study proper staffing levels within the VBA, because four years of mandatory overtime is a warning flag that has been waving to tell us we’re not supplying enough staff to deal with the backlog of veterans’ claims.

Whether it is appeals or initial claims, a backlog is a backlog, and the budget must reflect sufficient resources to address these claims, otherwise veterans will be forced to do what we have become all too familiar with, wait.

Conclusion:

The VA cannot afford to be run as an entity reactive to one crisis after another. Effectiveness stems from long term planning, and to be truly effective that long term planning needs to include all stakeholders. While there are other areas that can benefit from predicting crises before they occur and providing resources to perceived needs, these three areas represent a key start in the sort of thinking that must be adopted to make VA successful in the long run.

In order to assimilate all outside care under one cohesive management authority VA needs the budget flexibility to utilize the Choice Card funds for community care as well as to see a boost to community care funding commensurate with the increased demand. The VACAA infused \$10 billion in care funding because there was an emergency, but the demand has not gone away and future funding levels must reflect this as part of the plan, not a reaction to a crisis.

¹⁰Testimony of The American Legion - HVAC Hearing February 11, 2015

¹¹See *Jaquay v. Principi*, 304 F.3d 1276, 1280 (Fed. Cir. 2002); *Nolen v. Gober*, 222 F.3d 1356, 1361 (Fed. Cir. 2000); *Hensley v. West*, 212 F.3d 1255, 1262 (Fed. Cir. 2000).

There must be attention paid to VA's hiring and incentives, and if additional resources are needed to secure key providers like psychologists and physician's assistants, then VHA must be provided with the funding needed to secure those key performers. That is the long term key to ensuring veterans get the care they need in a timely fashion in the system that is designed to treat their unique wounds of war.

Four years of mandatory overtime and reassignment of DROs needs to stop if VA is going to prevent the growing appeals backlog from reaching disaster levels. Funding must be given to better assess the workforce within VBA and to provide the full time employees needed to accomplish the mission while keeping top assets like DROs working on the work they do best.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or ideplanque@legion.org

