

MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2016

TUESDAY, APRIL 21, 2015

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

The subcommittee met at 2:31 p.m., in room SD-124, Dirksen Senate Office Building, Hon. Mark Kirk (chairman) presiding.

Present: Senators Kirk, Murkowski, Hoeven, Collins, Boozman, Capito, Cassidy, Tester, Murray, Reed, Udall, Schatz, Baldwin, Murphy, and Mikulski.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. ROBERT A. McDONALD, SECRETARY

ACCOMPANIED BY:

STEPHEN WARREN, CIO, OFFICE OF INFORMATION AND TECHNOLOGY

DR. CAROLYN M. CLANCY, INTERIM UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION

DANNY PUMMILL, PRINCIPAL DEPUTY UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. Let's begin.

Tom Fuller, who you know about, was a Vietnam veteran in the Marines, and presented himself to the Hines VA with chest pains, went to see Dr. Dieter, who was the head of cardiology at Hines, and Dieter did not want him to be in his win/loss record, referred him to the floor, and there Tom expired of a heart attack.

I want to make sure that kind of thing never happens to our veterans, that we have confident, strong, administration of our people. Mr. Secretary, I have raised this issue with you multiple times.

Behind that is the story of Lisa Nee, who is a cardiologist, as she witnessed this whole thing and thought it was an outright malpractice happening in this case.

I know you have a 10 minute opener, Mr. Secretary.

Senator KIRK. Senator Tester.

STATEMENT OF SENATOR JON TESTER

Senator TESTER. Thank you, Mr. Chairman. I have a pretty brief opening statement, and then we will get after it. I just want to

thank Chairman Kirk for his leadership on this subcommittee, and I want to welcome Secretary McDonald, Dr. Clancy, and Mr. Pummill, and thank you for your work as you appear before this subcommittee, and your commitment to this Nation's veterans.

Mr. Secretary, it is good to see you again. Thank you for coming to Montana. It was a great trip, very informative, and I hope you feel the same way.

Moving forward, I hope that we can work closely together to address some of the concerns and issues raised during our trip, and some of the issues that will be raised today.

I have been impressed by your leadership, Mr. Secretary, your candor, your willingness to accept accountability and confront tough issues. I do not have to tell you, the Department of Veterans Affairs (VA) is an agency that is under siege every day. You experience that every day. We have seen several scandals that have shaken the confidence of the VA, have created mistrust for some of our veterans, and have created mistrust with some of our public.

Restoring that trust is one of your chief tasks, and I know you know that, but a lot of that responsibility also falls on our shoulders. It is critical that we provide you with the tools you need to get the job done.

I firmly believe that we need to hold accountable those who have abused their authority for personal gain, but also I believe that we need to appropriately recognize and applaud the dedication of the vast majority of VA employees who come to work every single day with the singular goal of helping every veteran whose lives they touch.

Dedicating all our time to pummeling—no pun intended—the VA for past failures is not a recipe for reform or success, and our veterans deserve more than that. At the end of the day, we are in this together, and by law and fully supported by Congress, American veterans are entitled to a healthcare system and benefits program that is far superior to any comparable government or private sector benefits, and for very good reason.

The VA model of providing direct healthcare and benefits to our Nation's veterans is something our veterans have come to rely on. It is something that Congress has enshrined in law.

We each have a responsibility here to sustain this model of service. The VA must reform and improve its delivery of services to veterans, and Congress needs to step up and fulfill the responsibility to fully fund the VA's model of service that veterans have come to expect and demand.

I want to thank you again, Mr. Secretary, Dr. Clancy, Mr. Pummill, for being before this subcommittee. I look forward to your testimony. Thank you, Mr. Chairman.

SUMMARY STATEMENT OF HON. ROBERT A. McDONALD

Secretary McDONALD. Chairman Kirk, Ranking Member Tester, and members of the subcommittee, thanks for the opportunity to discuss VA's 2016 and 2017 advance appropriations requests and budget.

We appreciate your steadfast support for veterans and the assistance of veteran service organizations (VSOs).

As VA moves from a serious crisis, we have a critical opportunity. We intend to take full advantage of it, to make VA a model agency and customer experience comparable to the best private sector businesses.

Currently, 11 million of 22 million veterans are registered, enrolled, or use at least one VA benefit or service. The cost of fulfilling our obligations grows over time because veterans' demands for services and benefits continue to increase.

In 2014, 40 years after the war ended, 22 percent of Vietnam veterans were receiving service connected disability benefits. We expect that percentage to continue to increase. From 1960 to the year 2000, the percentage of veterans receiving VA compensation was about 8.5 percent, but in the last 14 years, that has more than doubled, to 19 percent.

In 2009, the Veterans Benefits Administration (VBA) completed about 987,000 claims. In fiscal year 2017, we project we will complete over 1.4 million claims, a 47-percent increase.

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

From 1950 to 1995, the average degree of disability amongst veterans was 30 percent. Since 2000, the average degree of disability has risen to 47.7 percent. While the total number of veterans is declining, the number of those seeking care and benefits is increasing due to more than a decade of war, agent orange related claims, an unlimited claims appeal process, increased claims issues, far greater survival rates of the wounded, and more sophisticated medical treatments.

It is important to understand why. The most important consideration is an aging veteran population. Forty years ago, 2.2 million veterans were 65 years old or older. That is 7.5 percent of the population. In 2017, we expect 9.8 million will be 65 years or older. That is 46 percent. We now serve an older population with a greater demand for care, more chronic conditions, and less able to afford private sector care.

As veterans see positive changes at VA and as the military downsizes, those choosing VA will continue to rise. We are listening hard to what veterans, Congress, employees, and VSOs tell us, driving us to a historic Department-wide transformation, changing VA's culture, making veterans the center of everything we do.

We call it MyVA. MyVA focuses on five objectives to revolutionize culture and focus on veterans' outcomes rather than internal metrics.

First, improving the veteran experience so that every veteran has a seamless, integrated and responsive customer service experience every single time.

Second, improving employee experience by eliminating barriers to customer service and focusing on our people and our culture to better serve veterans.

Third, improving our internal support services.

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

Last, fifth, enhancing strategic partnerships. We cannot do this by ourselves. Strategic partnerships become critical.

Reorganizing the Department geographically is a first step in achieving this goal. In the past, VA had nine disjointed geographic organization structures. Our new organization framework has one national structure with five districts aligning VA's organizational boundaries. Veterans will see one VA rather than multiple disconnected organizations.

Last, MyVA is about ensuring sound stewardship of taxpayer dollars, will integrate management improvement systems to ensure operational efficiency. We need congressional help. VA cannot be a sound steward of resources with our current portfolio of assets. No business would carry such a portfolio.

It is time to close old substandard and under utilized facilities, 900 VA facilities are over 90 years old. More than 1,300 are over 70 years old. VA currently has 336 buildings vacant or less than 50 percent occupied. That is 10.5 million square feet of empty space costing about \$24 million annually.

We could use these funds to hire roughly 200 registered nurses for a year, pay for 144,000 primary care visits of veterans, or support 41,900 days of nursing home care for veterans. Please help us do the right thing.

MyVA reforms will take time, but in the long term, they will enable us to better provide veterans earned benefits and earned services.

Our 2016 VA budget request allows us to continue transforming under MyVA. It requests \$168.8 billion, \$73.5 billion in discretionary funds, and \$95.3 billion in mandatory funds, a discretionary request increase of \$5.2 billion above the 2015 enacted level, to continue serving the growing number of veterans seeking care and benefits.

The resources required in the 2016 budget request are in addition to those Congress provided in the Veterans Choice Act. We do not know how many veterans will ultimately use the act for non-VA care, what we call community care, or how much it will cost, our estimates range from \$4 billion on the low end to \$13 billion on the high end.

We do know that our recent decision to change the definition of the 40 mile provision of the act from straight line to road distance will approximately double the number of veterans eligible for care under the act.

As Deputy Secretary Sloan Gibson testified last week, we proposed funding the increased cost of our new Denver Hospital by requesting funds from the Choice Act. The Denver project has a long history. While poor VA project and contract management contributed to problems, decisions made years ago brought us to this point.

In my opinion, the significant increase in the cost of the Denver project results from four factors: first, not locking down design early in the process. Second, some design aspects that added costs. Third, increases to construction costs in the Denver market while we had not effectively negotiated a firm target price, and fourth, premiums paid to contractors for perceived risk due to problems with the project.

We have learned from these past mistakes and are taking meaningful corrective actions to improve performance. Among those actions are requiring major medical construction projects to achieve at least 35 percent design prior to publishing costs and schedule information or requesting funds.

Second, implementing a deliberate requirements control process, any significant changes in project scope or costs will be approved by me prior to submission to Congress.

Third, institutionalizing a project review board similar to what the Corps of Engineers District Offices use.

Fourth, conducting pre-construction reviews of major projects, and fifth, integrating medical equipment planners into the construction project teams from concept through activation.

Those measures will help us in the future but they will not finish Denver. After analysis by the Corps of Engineers, we informed the subcommittee that the total estimated cost of the facility will be \$1.73 billion, an authorization increase of \$930 million, and additional funding of \$830 million.

We believe requesting funds from the Choice Act is the best approach among the difficult choices before us. Now we must work with this subcommittee and others to secure the funding.

Last, if the President's budget request is cut by the \$1.4 billion proposed by your colleagues in the House, those reductions would have these effects: it would cut veterans' medical care by \$690 million, the equivalent of over 70,000 fewer veterans receiving VA medical care compared to the President's request.

It would eliminate the funding for four major construction projects. This cut would reduce VA's ability to provide additional outpatient services and will impact the following projects: the planned rehab therapy building in St. Louis, Missouri; the initial phase of the Alameda, California outpatient clinic; construction of the long sought after French Camp, California community-based outpatient clinic (CBOC); the replacement 155-bed community living center in Perry Point, Maryland.

It would also eliminate funding for cemetery expansion projects in St. Louis, Portland, Riverside, and Pensacola, and a new columbarium in Alameda, reducing our ability to provide burial honors for as many as 18,000 veterans and eligible family members annually.

The impact of these cuts to veterans' care and benefits is unacceptable to me, and I know it is unacceptable to members of Congress.

Mr. Chairman, ranking member, members of the subcommittee, thanks again for your support for veterans and for working on these budget requests. We look forward to your questions. Thank you, Chairman.

[The statement follows:]

PREPARED STATEMENT OF HON. ROBERT A. McDONALD

Chairman Kirk, Ranking Member Tester, Distinguished Members of the Senate Appropriations Subcommittee on Military Construction and Veterans Affairs:

Thank you for the opportunity to present the President's 2016 budget and 2017 advance appropriations (AA) requests for the Department of Veterans Affairs (VA). This budget continues the President's staunch, unwavering support for veterans, their families, and survivors. We value the support to VA that Congress has dem-

onstrated in providing the resources and legislative authorities needed to honor our Nation's veterans.

This is a critical moment for VA. We are emerging from one of the most serious crises the Department has ever experienced. But with this crisis, VA also has before it perhaps the greatest opportunity in its history to enhance care for veterans and build a more efficient and effective system. We are listening hard to what veterans, Congress, employees, Veterans Service Organizations (VSOs), and other stakeholders are telling us. Since my nomination on June 30, 2014, I have made more than 100 visits to VA field sites—including 31 visits to VA Medical Centers, nine visits to VA Community-Based Outpatient Clinics and 10 visits to Homeless Veteran program sites. I participated in the Los Angeles Point-in-Time Homeless Veterans count. I've made six visits to VA Regional Offices and six visits to VA cemeteries. I have witnessed first-hand the operations at VA polytrauma centers, a veterans community living center, a hospice, an insurance center, and a domiciliary. I have attended 29 veteran engagements through partnerships and 25 stakeholder events. I have also visited 16 medical schools and universities to recruit newly minted clinical professionals for VA's healthcare system. All of these visits are influencing the way VA is moving forward. We are implementing an historic department-wide transformation, changing VA's culture, and making the veteran the center of everything we do. We aspire to make the VA a model agency that is held up as an example for other Government agencies to follow with respect to customer experience and stewardship of the taxpayer's resources. We strive to be comparable to the very best private sector businesses, with efficient and effective operations.

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

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

MyVA—DRIVING REFORMS AND IMPROVING EFFICIENCY

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

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

- Improving the veteran experience

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

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

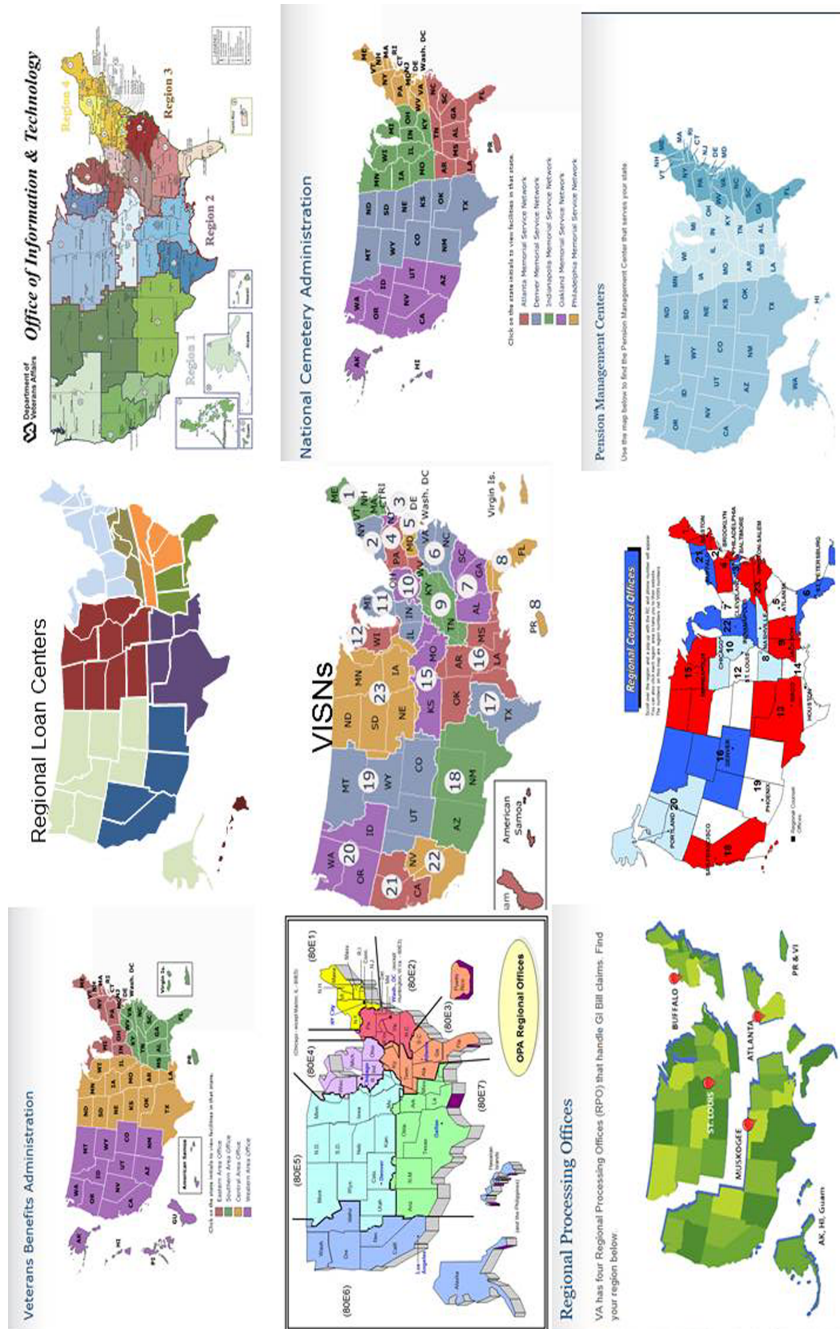
MyVA will empower employees with the tools they need to better serve veterans, and will revolutionize VA’s culture by emphasizing continuous improvement, setting conditions at the local level for issues to be raised, addressed, and solutions replicated across as many facilities as needed to achieve enterprise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

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

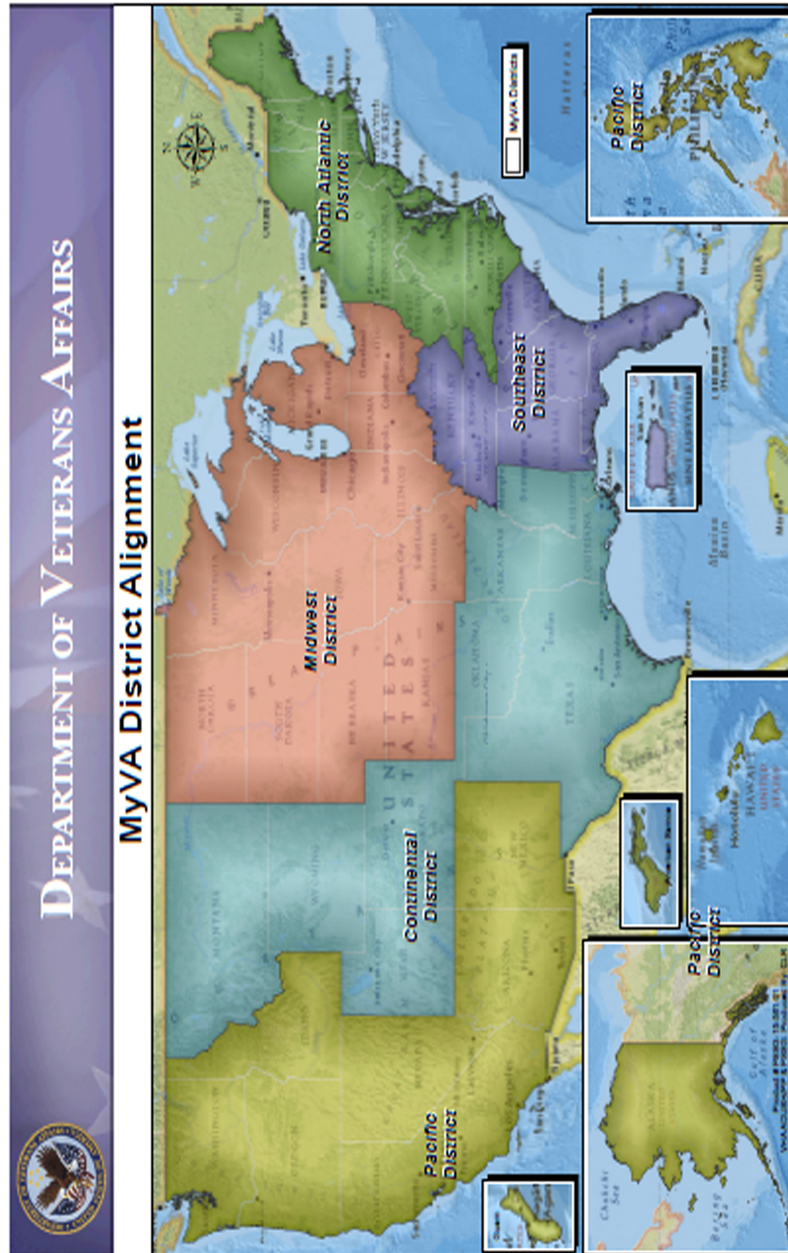
In addition, we are creating a new Digital Services Team, comprised of the country’s best developers, designers, and digital product managers, who will work across VA to design and deploy world-class digital services for America’s veterans. Our digital services experts will help the Department achieve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

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

Before: VA's Nine Organizational Maps



After: A Single, Coordinated Framework

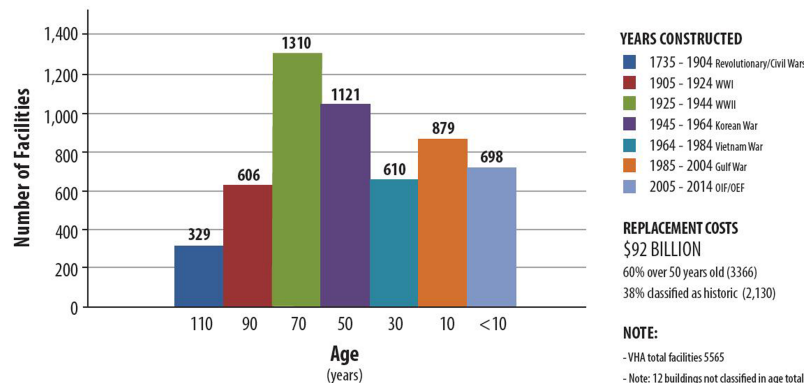


CLOSING UNSUSTAINABLE FACILITIES

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

VHA's Aging Infrastructure

60% of VHA facilities more than 50 years old



We need to move forward with closing locations that are not economically sustainable and old, outdated buildings that are challenging to maintain and provide little or no value to our customers. VA currently has 336 buildings that are vacant or less than 50 percent occupied, which are excess to our needs. This means we have to maintain over 10.5 million square feet of unneeded space—taking funding from needed veteran services. For example, we estimate that it costs VA \$24 million annually to maintain and operate vacant and underutilized buildings. These funds could be better used to hire roughly 200 Registered Nurses for 1 year; pay for 144,000 veteran primary care visits; provide veterans 13,500 bed days of inpatient care; or support 41,900 days of nursing home care for veterans in Community Living Centers. The President's 2016 budget includes two legislative proposals that would aid VA in disposing of these unnecessary assets. The first is the Government-wide Civilian Property Realignment Act, which would enable Federal agencies to pursue consolidation and disposals in a streamlined way. The second proposal would authorize VA to pursue Enhanced-Use Lease (EUL) agreements beyond the currently authorized purpose of creating "supportive housing" as defined in 38 U.S.C. §8161(3). Our existing EUL authority does not allow VA to enter into a wide range of innovative agreements that could benefit veterans.

VA faces many obstacles to rightsizing our capital asset portfolio. For example, under an Enhanced Use Lease project, VA's selected third-party developer sought to demolish the vacant building shown below in order to provide land for the development of housing for homeless veterans. The state historic preservation office did not support the developer's plan to demolish the building, so in the interest of time and funding, the developer decided to forego demolishing the building. This action forced VA to incur the costs to mothball and maintain this unneeded building and limited the amount of land that was available to redevelop to provide housing for veterans. I have met with National Historic Building advocates to discuss repurposing the buildings we close, and look forward to a spirited, positive dialogue on this issue.



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

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

VA needs to better align its healthcare facilities to meet today's healthcare delivery models, which are shifting away from long inpatient stays to greater outpatient care. We also need to modernize our facilities to ensure they provide ready access to women, who now comprise 11 percent of all veterans and 20 percent of our military. Where hospitals no longer make sense, due to a declining veteran population or demographic shifts, VA must look for ways to partner with local hospitals and healthcare systems to serve veterans. Much of healthcare today is about creating partnerships and interdependencies to better serve patients and to contain costs. VA must be part of that.

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

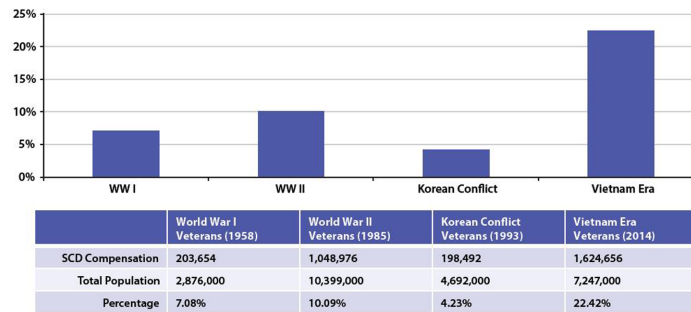
VETERANS' DEMAND FOR SERVICES AND BENEFITS

We know that veterans' demand for services and benefits continues to rise for decades after conflicts end. And we know that the veteran population is aging. In 2017,

9.8 million, or 46 percent of the 21.1 million veteran population will be age 65 or older. This compares with 2.2 million, or 7.5 percent, in 1975. veterans' care often occurs many years after they served in uniform, so this is a long-term issue for VA. Just since 2002, the number of veterans receiving outpatient services has grown by more than 76 percent.

Veterans Receiving Service Connected Disability Compensation

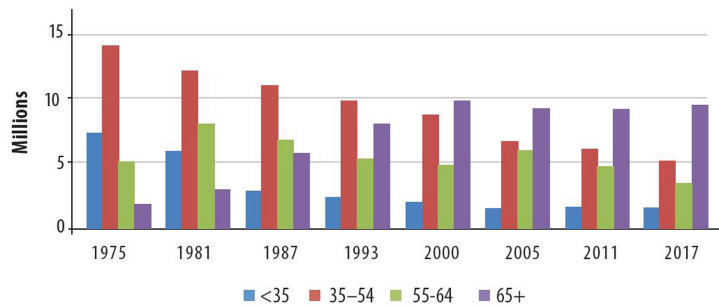
40 years after conflict ends



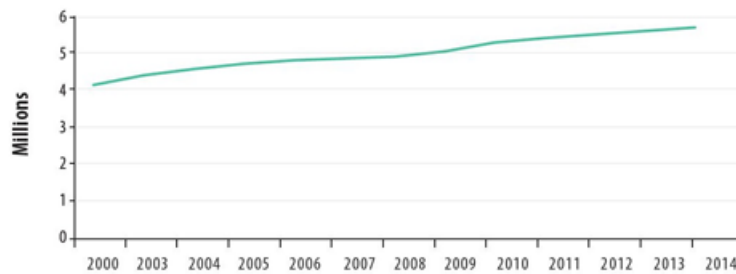
Note: Date in parentheses is the date of data used in the chart.
Data Source: 1958 VA Annual Report; 1985 VA Trend Data 1961-1985;
1993 VA Trend Data 1969-1993; 2014 VBA OPIA and Veteran Population Model

Number of Living Veterans

by Age Groups, 1975-2017

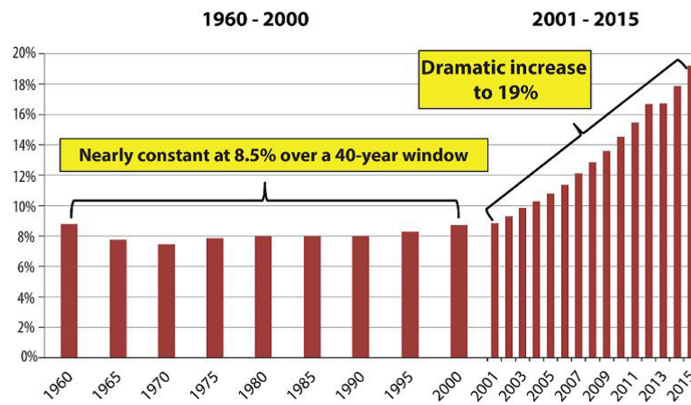


Number of Veterans Unique Outpatients
2002-2014 (in millions)

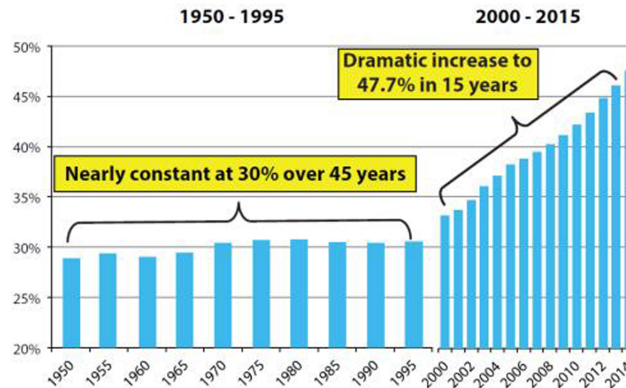


Fueled by more than a decade of war, Agent Orange-related disability compensation claims, a complex, non-linear claims appeal process, demographic shifts, increased medical claims issues, and other factors, veterans' demand for services and benefits has exceeded VA's capacity to meet it. VA has worked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

Percent of Veterans Receiving Disability Compensation



Average Degree of Disability



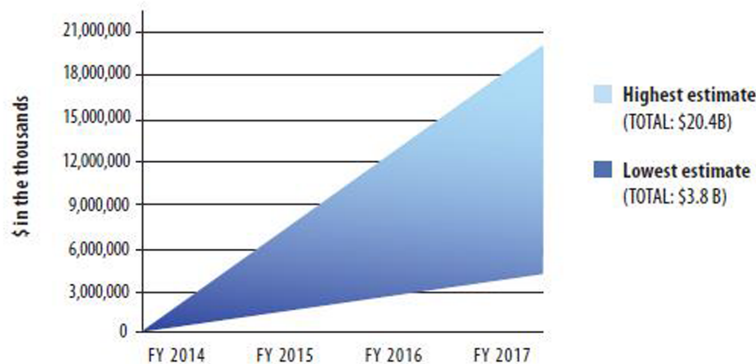
We must ensure that demand for services and benefits does not outstrip our capacity to provide them. VA must build the capacity now to meet future demand. We look forward to working with you to identify and prioritize spending to best serve the interests of veterans and our Nation.

THE VETERANS ACCESS, CHOICE, AND ACCOUNTABILITY ACT OF 2014

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

The emergency resources provided in the Veterans Choice Act are not permanent, but are being used to address the current access crisis, but do not fully address VA's longstanding capital infrastructure requirements. Because VA has limited experience with the new Veterans Choice Program, it is difficult to predict veterans' use of the program, or its interaction with the medical care base budget. Our current estimates of the total healthcare costs for the Choice Program range from a low of \$3.8 billion to a maximum of \$20.4 billion over the 3-year program.

Cone of Uncertainty Surrounding Cost of Veteran Participation in Veterans Choice Program



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

The variance is the result of significant uncertainty surrounding eligible veterans’ participation and utilization of non-VA medical services. Two categories of veterans are eligible to participate—those living outside the Act’s 40-mile distance, which as of April 24, 2015 will be refined to reflect driving distance (fastest) from the nearest VA facility including CBOCs, or when we cannot provide care within 30 days of the clinically indicated date or preferred date of the veteran. Each eligible veteran must make his or her own decision about care in the community. For example, a veteran may prefer to be seen at the VA by his or her regular doctor, even though there is a waiting period, rather than see a new private sector physician in a shorter time period. Also, wait times may be high in the community for specialty appointments, and veterans may elect to receive their specialty care from VA.

ENSURING VETERANS ACCESS TO CARE

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

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

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

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

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

ENDING VETERAN HOMELESSNESS

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

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

MEDICAL AND PROSTHETIC RESEARCH



VA has a legacy of innovation and cutting-edge research that is as broad and historically significant as it is profound—and often unrecognized. Few are aware that VA research developed the cardiac pacemaker, the first successful liver transplant, the nicotine patch, and the world's most advanced prosthetics—including VA's revolutionary “Braingate” breakthrough that makes it possible for totally paralyzed patients to control robotic arms using only their thoughts.

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

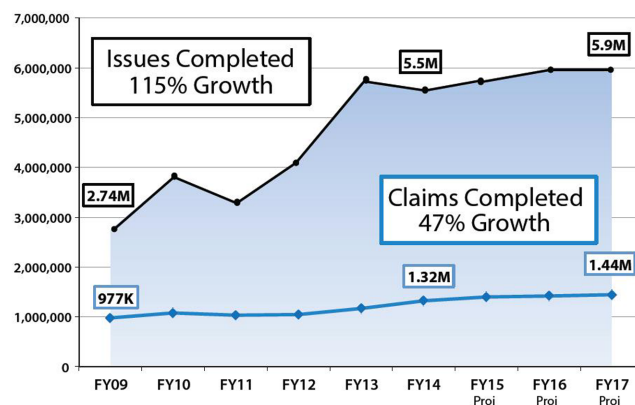
The 2016 budget includes a \$10.2 million strategic initiative to support improvements in VA medical care through research focused on a “Learning Health Care System.” A learning healthcare system is one that is responsive to new information, adapts to implement more effective clinical practices, and is committed to an ongoing

ing mission of excellence, supported by a culture of self-reflection and continuing education. Through five interlocking research streams—measurement science, operations research, point-of-care research, provider behavior, and randomized program implementation—this initiative proposes to broaden existing research by systematically capturing, assessing, and translating the lessons from each care experience into improved methods of delivering care to veterans.

CONTINUING THE TRANSFORMATION OF THE VETERANS BENEFITS ADMINISTRATION

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

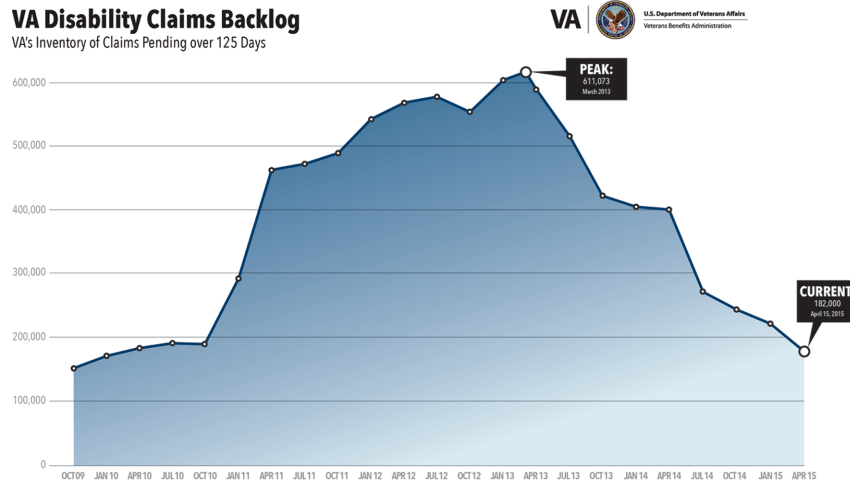
Claims and Medical Issues Completed



Despite these challenges, VBA has decreased the disability claims backlog by more than 70 percent as of April 15, 2015, since its peak in March 2013 (from 611,000 to 182,000), and we are on track to meet the President's goal to eliminate the disability claims backlog by processing all claims in 125 days by the end of 2015. VBA's success in reducing the backlog has occurred, in part, because of its strong reliance on mandatory overtime by claims processors. However, this strategy is unsustainable. It strains employee-management relations and is inconsistent with our goal to improve the employee experience so they can be empowered to better serve veterans. We must right size VBA's workforce and more effectively manage the use of management practices such as the use of mandatory overtime and continue progress toward eliminating the disability claims backlog.

VA Disability Claims Backlog

VA's Inventory of Claims Pending over 125 Days



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

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

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

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

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

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

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

VBA is able to accommodate additional staff within existing space requirements by efforts underway to digitalize veterans claims folders, building on success to date.

One example is the VBA office in Winston-Salem, North Carolina, which is shown below before and after VBA digitized veterans' paper records.

Winston-Salem Regional Office: Before and After Transformation



Spring 2012



Fall 2013

The VBA request includes \$140.8 million for continued investment in the Veterans Claims Intake Program (VCIP), which converts paper claims into an electronic format and enables the electronic transfer of medical and personnel records. This electronic transfer is critical to creating the necessary digital environment that supports end-to-end electronic claims processing for each stage of the claims lifecycle. As of December 2014, over 28,000 users of the Veterans Benefits Management System (VBMS) could access over one billion electronic images converted from paper.

The Budget request for the 2017 advance appropriations for the Compensation and Pensions appropriation is \$87.1 billion; the Readjustment Benefits advance appropriation request is \$16.7 billion; and the Veterans Insurance and Indemnities ad-

vance appropriation is \$91.9 million. These amounts reflect the current estimates for the resources that would be necessary to continue these benefit programs in 2017, and will be revised as necessary in the mid-session review of the 2016 Budget, as VA monitors workload and monthly expenditures.

ENHANCED FOCUS ON INFORMATION TECHNOLOGY SOLUTIONS

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

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

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

INVESTING IN VA'S INFRASTRUCTURE

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

Major Construction

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

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



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





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

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

Minor Construction

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

Leasing

The 2016 budget includes a request to authorize 18 major medical facility leases under VA's authority at 38 U.S.C. §§ 8103 and 8104, to provide access to veterans and enhance our research capabilities nationwide. The proposed major medical facility lease projects are to replace, expand, or create new outpatient clinics and research facilities. The request includes resubmission of five leases that were originally submitted in 2015, but have not yet been authorized.

Additionally, since the inception of the EUL program codified at 38 U.S.C. §§ 8161–8169, VA has entered into approximately 100 EUL projects, leveraging approximately 5.8 million square feet and over 1,000 acres of excess property to repurpose in support of veterans, VA, and local communities across the country. VA needs the support of Congress for our proposed amendments to expand our current EUL authority beyond supportive housing projects so we can better leverage our excess space for veterans. In addition, this proposed enhancement would allow VA to monetize unneeded assets to raise capital to address needed investments in VA's system.

LEGISLATION

In addition to presenting VA's resource requirements, the 2016 President's budget proposes legislative action that will benefit veterans. VA's most critical legislative request is for a significant update to VA's authorities for purchase of non-VA

healthcare. The administration is proposing a streamlined process for purchasing healthcare needed for veterans in those circumstances where it cannot be purchased through existing contracts or sharing agreements. The proposal takes care to preserve important features and protections found in traditional contract vehicles. Current law is simply not adequate to support the continued level of access to healthcare we need to secure for our veterans. We look forward to detailed engagement with the subcommittee and your staff.

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

As mentioned earlier, VA will propose a measure that would allow a portion of the Veterans Choice Act funds to be used for essential operational requirements. In addition, the legislative proposals would allow for better coordination of care when a veteran also receives other care at a non-VA hospital, by streamlining the exchange of patient information. Additionally, we propose allowing the CHAMPVA to cover children up to age 26, to make that program consistent with benefits conferred under the Affordable Care Act.

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

CLOSING

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

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

DENVER MAJOR CONSTRUCTION PROJECT

Senator KIRK. Thank you, Mr. Secretary. On Denver, I would ask unanimous consent if I can put in a statement that Cory Gardner gave us on this issue.

[The statement follows:]

PREPARED STATEMENT OF SENATOR CORY GARDNER

Chairman Kirk and Ranking Member Tester, I'd like to thank you for holding this hearing and for giving me the opportunity to express my concern over the U.S. Department of Veterans Affairs (VA) management of the Denver Replacement hospital. In addition, I'd like to state my full support for the completion of the hospital, which will serve hundreds of thousands of veterans in Colorado and the Rocky Mountain

Region. To that end, I urge the subcommittee to include funding for the construction of the Denver Replacement hospital in the upcoming appropriations legislation.

The VA has a history of failing Colorado veterans, and this mismanagement of the construction of the Denver Replacement hospital is just the latest unfortunate example. The VA's failed management of the construction of the Denver Replacement hospital has resulted in the facility being nearly \$1 billion over budget and months behind schedule. For this reason, I've joined with Congressman Mike Coffman to introduce the "VA Construction, Accountability, and Reform Act" in the House and the Senate.

The purpose of this legislation is to complete the Denver Replacement hospital and hold those officials responsible for its delay accountable. Three key provisions in the legislation will accomplish these goals.

First, the legislation transfers management of all medical construction projects from the VA to the Army Corps of Engineers. Since the Corps has experience with major construction projects, this provision ensures that the Denver Replacement hospital will be completed without further delays and cost overruns. And going forward, removing the VA from the construction business will help ensure future VA hospitals avoid similar mismanagement.

Second, the legislation seeks to offset the existing cost overruns of the facility by stopping staff bonuses at the VA and using the money saved to cover the additional cost of the Denver Replacement hospital.

Thirdly, the legislation requires the Comptroller General of the United States to review the Secretary of the VA's management of the replacement hospital and determine if misconduct or criminal activity by VA employees may have contributed to the significant cost overruns of the replacement facility. This review would establish when senior officials at the VA should have known the replacement facility was likely to incur cost overruns, and what the justification was for the Secretary of the VA to withhold information relating to such significant cost overruns from Congress.

Through these provisions, I believe this legislation will provide accountability of taxpayer dollars, complete the construction of the Denver Replacement hospital, and ensure that our veterans never again have to wait for care while the VA fails to complete a construction project.

Senator KIRK. With that \$1.73 billion, Denver Hospital will take up so much money, funding for MILCON for our missile defense for 7.9 years, it would also take up 4 years of MILCON for Special Operations. That is an awful big hit.

I would add to your list of things that were done wrong in Denver is you did not have the Army Corps of Engineers overseeing the construction of the facility. I want to make sure that by June 1 you have already done that.

Secretary McDONALD. Mr. Chairman, we have already done that as of today. The Corps of Engineers is active on the ground, we are working with them in concert, and we continue to want to use the Corps of Engineers on other major projects.

May I make a statement, Mr. Chairman? This is not really a hospital. This is a medical complex. This is what the complex looks like, and as you can see, it is many buildings. It is not just one building. It is very close to University of Colorado Medical School, who is a partner of ours.

This is a major undertaking of many buildings, just not one hospital. I just wanted to be clear on that, sir.

Senator KIRK. I would say that your proposal has been to take \$1 billion from the Choice Act to sink into this thing, and that would eliminate about 20 percent of the Care Act money. The promise we have already made to America's veterans, we do not want to welsh on that promise because of the mismanagement of the Denver facility. We need to have the people involved with this fired and no longer a part of the payroll.

Secretary MCDONALD. The gentleman that was in charge of construction at VA is no longer with us. We conducted an administrative investigation——

Senator KIRK. By “no longer with us,” it means you let him quietly retire, he is still collecting from the taxpayer.

Secretary MCDONALD. He retired. He chose to retire the day after the interview that he had, and to the best of my knowledge, both in the private sector and in the public sector, it is impossible to call back a retirement unless malfeasance is proven, and the investigation is ongoing.

Senator KIRK. We had evidence of a whistleblower who sent an e-mail very early on and said this project is likely to go \$500 million over budget, and that whistleblower was fired by VA because of that e-mail.

I want to make sure this continued process of nailing whistleblowers is wiped out in the VA. How would we have that happen?

Secretary MCDONALD. I am not familiar with the situation you are describing, but I would love to be able to get more information on that and follow up.

We have been working with the Office of Special Counsel to make sure that all of the whistleblowers who have been retaliated against——

Senator KIRK. Let me just get it for the record, the person that you were talking about was Glenn Haggstrom?

Secretary MCDONALD. Yes, sir.

Senator KIRK. The person who sent the e-mail saying we would go \$500 million over budget was a Adelino R. Gorospe, and that person was let go, and turned out to be exactly correct on all the warnings to VA on that subject.

Secretary MCDONALD. As I said, we have said within the organization it is unacceptable to retaliate against anyone who is criticizing our operation. In fact, we believe that we want employees to help us improve our operation, and the only way that can happen is if they are critical.

We have worked with the Special Counsel to get certified in our activities around whistleblowers. We have reinstituted several whistleblowers to new jobs. We celebrated with a national award some of our whistleblowers, one in particular from Phoenix, and we are committed to make sure whistleblowers are not retaliated against. It is just unacceptable.

Senator KIRK. I want to make sure we do not wipe out the Choice Act money for the overrun in Denver, that we stand by our veterans there.

Secretary MCDONALD. We just do not know how much of the Care money will be used, the Choice money will be used, and how quickly.

Senator KIRK. Mr. Secretary, I understand if we just wrap up the Denver situation, it would cost \$3 million a month to maintain that. Do you understand that to be true?

Secretary MCDONALD. I am not familiar with that figure. We do not have that figure, but we will check on it.

Senator KIRK. Let me go to Mr. Tester.

Senator TESTER. Thank you, Mr. Chairman. It goes without saying the chairman, myself, and everybody on this subcommittee

knows how important this subcommittee is to our veterans in the country and how we need to do a job together.

HOUSE COMMITTEE MARK

With that being said, I would note that the House subcommittee mark came in about \$1.4 billion, as you pointed out, below your request. They achieved this largely by freezing the major construction level, fiscal year 2015 levels, including a number of other funding cuts.

In the past, there have been a lot of folks on this side of the dais that have criticized the VA for not being frank about what you need for money. A lot of criticism was warranted and it led to funding shortfalls and subsequently had to be addressed through numerous legislation, such as the Choice Act.

Now, a lot of the folks who demanded more results from you are the same folks who refused to give you the flexibility and the resources you needed to achieve the results that our veterans need when they come to see you.

Is it fair to say that the House subcommittee mark is inadequate?

Secretary McDONALD. It is inadequate. It will cost veterans to suffer.

As I said in the House subcommittee hearing on the budget, we put in this budget knowing that it was going to be very tight versus the demand that we faced, and in addition to the budget itself, we wanted flexibility to be able to move money from line item to line item because as I said to the chairman, we cannot predict whether veterans are going to go for community care with the Choice Act or whether they are going to go with VA care.

Because of the way the budget is formed, I do not have the flexibility to move money where the veteran goes.

Senator TESTER. Is it also fair to say that due to Vietnam veterans getting older, you are getting a lot more demand on your facilities, and if that is true, can you tell me what that \$1.4 billion spending cut would mean to the veterans and to their families?

Secretary McDONALD. The \$1.4 billion spending cut basically means less veterans are going to get care. The medical care has been cut by \$690 million, which is the equivalent of 70,000 fewer veterans receiving VA medical care.

Senator TESTER. As you see demand go up, you are not going to be able to come close to—

Secretary McDONALD. We will not have the money to care for them.

VA RECRUITMENT EFFORT

Senator TESTER. Okay. Hiring. We have discussed this several times. We have given some increased funding and enhanced mechanisms to address workforce shortage in the VA. It looks as if it is static at best. We could be losing ground. It seems we are battling on two fronts, not only attracting new physicians and medical personnel, but keeping the ones we already have.

The VA needs the authority and resources to hire good, competent personnel and let them do their jobs, and then hold them accountable for the outcomes.

I am worried that the cascading negative press about the VA, its personnel, and the care it provides is crushing the Department's ability to address workforce needs that we have in Montana and I assume elsewhere in this country.

This is not to excuse any of the wrongdoing or to dismiss any of the legitimate allegations of misconduct, but a lot of folks around here are quick to go after a headline at the expense of hard-working men and women who actually are doing their jobs, working with the veterans, even if it means less pay and longer hours.

My question to you as the head man, to what extent has this impacted your ability to recruit to the VA?

Secretary McDONALD. Senator Tester, as you know, I have been to over a dozen medical schools and I have talked to candidates to become nurses and doctors at the VA. The constant haranguing on things that have gone wrong months ago, years ago, has affected the public perception of the VA, and it makes our recruiting job that more difficult.

We have increased the salary bands of our doctors. We are looking at competitive pay of other providers within our system. We have hired more doctors. We currently have hired over 800 more doctors, over 2,000 more nurses, and we have opened new facilities. We open about 17 new facilities a year.

But the demand, as you have suggested, has increased. We have gone from roughly 4 million outpatient patients to nearly 6 million. That demand is going to increase as we continue to improve the system and improve our customer service.

We have not even seen the full effect of the Iraq and Afghanistan wars yet and the veterans who have fought in those wars. We have to build the capability today to be ready for 5 years, 10 years, 20 years from now. That is what our plan does.

Senator TESTER. We will talk more about those capabilities next round.

Senator KIRK. Let me add on to that, I understand that Glenn Haggstrom, who you said was responsible for the debacle in Denver, got a \$60,000 bonus according to Senator Gardner. I would say if we are giving totally incompetent people big bonuses like that, how can we ever take care of our veterans.

Secretary McDONALD. I believe that bonus was for 2013 or before, and not recently. As I said, we have the administrative investigation going on, and as we get to the bottom of this, we will figure out what the appropriate action is.

Senator KIRK. Mr. Boozman.

Senator BOOZMAN. Thank you, Mr. Chairman. I agree with the Senator from Montana, the vast majority of the VA personnel are doing a great job and working very, very hard.

I think the thing that really shows that is how few have actually accessed the program that we are trying to stand up so they do not have to travel. Many of them are traveling even though they can stay home.

It is hard, and I understand the argument, and certainly I am going to bring up an issue that was before your time, and yet it is hard in the sense that people are losing faith, Congress is losing faith.

LITTLE ROCK, ARKANSAS SOLAR PANEL SYSTEM PROJECT

We have an issue in Little Rock. Congressman Hill has been looking into this very vigorously, where we had a situation in February 2012, the VA received an \$8 million grant to build an 1.8 megawatt solar panel system at the Veterans Hospital. In August 2012, the VA approved a parking deck project, which was located at the same place as the solar panels. In January 2013, construction on the solar panels began on the same location as the planned parking garage.

VA officials were aware of the conflict at the time. In August 2013, the solar panel construction was completed. In April 2015, the VA dismantled some to build the parking lot, and it is still not clear as to how much it is going to cost to put them back, and whether or not they were able to function in the grid to begin with.

I guess what I would like, we have these things going on, what are the safeguards that we have? How are you dealing with this kind of stuff?

Secretary McDONALD. I mentioned some of the changes we have made to the process of construction in my comments. I also mentioned that we have changed the leader. We have a new leader named Greg Giddens. He has experience across many sectors of government and has done this before. I also happen to be an engineer. My certification is in engineering training. I studied engineering at West Point. Our Deputy Secretary is a former CFO of a bank, very bright, intelligent guy.

We are digging into this in the strongest possible way, and I would just simply say that this is not going to happen. That happened in 2012. I appreciate you bringing it up. This is not going to happen in the future. It just is not going to happen.

What we are doing is we are having design committees, we are having outside people review our processes. We are using the Corps of Engineers. We are using the best practices that are available in industry today in order to make our system better.

Senator BOOZMAN. I think one thing that we have to be very careful of, that process started then, and yet I do not know how forthcoming VA was in admitting that the process was there. Even now, when you ask how much is it going to cost to reinstall, we get terms like procurement-sensitive, something like that. That is not appropriate.

Secretary McDONALD. I agree. We are trying to be more transparent and more communicative than ever before. I would hope that since I became Secretary, you have seen an increase in my presence.

Senator BOOZMAN. Yes, and I appreciate that.

Secretary McDONALD. And an increase in our transparency as a Department. I still every day do catch instances where I wish we were more transparent and better about customer service.

PROVIDER REIMBURSEMENT

Senator BOOZMAN. The other thing I would like to mention, and I want to compliment you in this regard, we had a group get together in Little Rock to discuss reimbursement to providers that have provided outside care. You will have situations that arise in

the VA where because of emergencies or now with this 40-mile rule, the VA owes money.

It appears that the VA owes lots of people in Arkansas a lot of money and has not been very forthcoming in paying those bills. That is a real concern really for a couple of reasons in the sense that it is another thing that makes it a trust issue that we talk about.

The other problem is if you do not pay your bills, they are going to quit dealing with you. That is the greatest thing, and that really is going to affect quality of care.

Can you quickly mention that?

Secretary McDONALD. I will, and maybe ask Carolyn to comment. I talked about our five strategies from MyVA. One of them I talked about was improving our internal support services, and going to a shared services model, where we centralize the bill paying so that is all that people do, and that is something we are in the process of doing. We are not done yet. We still have more work to do. That will dramatically improve the rates at which people get paid. Carolyn.

Dr. CLANCY. Yes. I would just add that we are tracking this rates of payments and hold old the claims on a weekly basis. I am pleased to say VISN 16, which had been struggling for a while, and that is what Arkansas is a part of, is actually improving faster than other networks, but we will keep a very close eye on it.

As you said, Senator, if you do not pay your bills, people are going to say gee, I would love to help you but I have to pay, and that is not going to work.

Senator BOOZMAN. Again, your people were very helpful and did a good job in Arkansas. Thank you, Mr. Chairman.

Secretary McDONALD. Thank you, sir.

Senator KIRK. Mr. Udall.

Senator UDALL. Thank you very much, Mr. Chairman. Let me along with the rest of the members echo your new aggressive leadership and what you are doing in terms of veterans. I really respect the team that you brought in, and this more business like approach to what is an incredibly important issue for veterans in my State and across the country.

Let me thank you, too, for the constructive dialogue we have been able to have moving the VA forward as you near the end of your first year as Secretary.

As we discussed during last week's visit, New Mexico's key issues can be narrowed down to ensuring veterans have access to care. Too often veterans are prevented from receiving the care they deserve because of barriers to access. Starting with disability claims, many veterans are not able to have their claim adjudicated in a timely manner.

NEW MEXICO CLAIMS BACKLOG

In New Mexico, progress to reduce the backlog has stagnated, and that is the chart I have behind me here. I think I have showed you that before, where we have come down dramatically, we have made good progress, but it is stagnated.

I am hopeful we can get the resources to make progress in reducing the backlog once again, and where it is stagnated, started in a downward turn.

ACCESS TO CARE

With regard to scheduling and the scheduling issue, last summer showed we had a lot of work to do to ensure that veterans are seen on time and the scheduling system was not being utilized in a fraudulent manner.

As I mentioned, I asked the VA OIG to look into this matter, and I am awaiting their findings. Furthermore, for rural veterans in New Mexico and across the country, we need to do more to find creative solutions to the recruitment and retention problem facing the medical community in rural clinics. This is not something that is solely a VA problem, but I believe it is an area that VA can take a leadership role to address.

Based on the budget requirements and the VHA's experience, which would be the best way—this has been mentioned by several questioners here and in some of your answers—which would be the best way to improve access to quality care, an expanded fee for service program, or a program which aims to recruit and retain rural physicians and nurses at rural CBOCs and which helps to expand telehealth? Which would be the most cost effective way for the American taxpayer? I know you have given this a lot of thought.

Secretary McDONALD. Sir, I think we need to do both. We envision a system in the future which is a combination of VA care and community care working together in a network to make sure our veterans get the care they want.

I would like to briefly comment on your chart.

Senator UDALL. Please.

CLAIMS BACKLOG

Secretary McDONALD. I think if you backed the time period up, you will see a more dramatic decline in the claims backlog, and also go back a couple of years.

I also think the reason it leveled out was we had 660 additional head count in the Choice Act for Veterans Benefits Administration because we had been working mandatory overtime in the Veterans Benefits Administration to drive this backlog down to zero.

As I was going around doing town halls amongst the people in Veterans Benefits Administration, I was seeing, not surprisingly, increasing conflict between labor and management. Mandatory overtime is not the way to run a business. That 660 people were stripped out of the Choice Act before it was passed. You did not give us, "you" Congress, did not give us those people.

We took off mandatory overtime hoping we could continue to drive it down. That straight line is when we took off mandatory overtime. It did not work. We had to put it back on. We are still doing mandatory overtime, which we have been doing now for several years, which is not a good idea.

We have more people in the 2016 budget that we need in order to get the backlog down. We are going to get to zero by the end of the year, but we need those people.

Also, I think there are a couple of months that are not on your chart. Danny, could you update us on that?

Mr. PUMMILL. Yes. First of all, great charts, your numbers are dead on. You did a really good job on it, or your staff.

Secretary McDONALD. We should say we publish our numbers every two weeks, so we want to be transparent and we want you to know what our numbers are.

Senator UDALL. We appreciate that.

Mr. PUMMILL. As we went back into mandatory overtime, we started pushing again. You see these dark oranges, that is your number pending. That has now come down.

Because that has come down, as of right now in April, you are down to 47 percent on the backlog, 3,500 claims pending, and 1,500 of those claims in the backlog, you will see the continued downward slope that you saw earlier in your chart for the next 3 months at a huge drop off this summer, because pretty soon every claim we are going to be working is going to be in the backlog, but that will not be just for your State, that will be for the entire Nation. We should have zero backlog this year.

TELEHEALTH

Secretary McDONALD. Maybe I can ask Carolyn to comment on telehealth, because this is a really important strategy for us.

Senator UDALL. I have run out of time, if you could very briefly, Carolyn.

Dr. CLANCY. I would just simply say that New Mexico is really a model with Dr. Arroyo at the University of New Mexico working closely with us.

This is a matter of if the veteran cannot come to the medical center, then we can use telehealth to bring that expertise to the clinicians working out in the rural communities. It has worked phenomenally and we are actually using it in other parts of the system as well.

Senator UDALL. Thank you very much. Dr. Arroyo, he is pretty amazing. Thank you. Thank you, Mr. Chairman. Thank you for your courtesy.

Senator KIRK. Mrs. Capito.

Senator CAPITO. Thank you, Mr. Chairman. I want to thank the Secretary and others for being here today. It is nice to see you again.

GREENBRIER OUTPATIENT CLINIC

I would really like to thank you and the VA for the flexibility and the willingness to work on the 40-mile rule. We talked about it. As you know, in a State like mine, West Virginia, 40 miles as the crow flies could be hours in a car sometimes. Making this change really helps veterans across the country, and certainly in my State. Thank you.

I know you are aware of this issue. I think we talked about it. It is in Greenbrier County. There is an outpatient clinic there. It has been closed three times for, I believe, mold in the facility, some unhealthy conditions in the facility because of air quality. I think I read that the Bluefield Mobile Unit is going to be serving the 2,400 veterans in that area.

I was wondering if you had—I know this is very specific—if you had any other alternatives, are you going to replace that facility, what your plans are for that.

Secretary McDONALD. I would like Carolyn to comment about the specifics. I would simply like to reiterate what I said. Our facilities are too old. HVAC systems need to be replaced about every 25 years. I talked to you about facilities that are over 100 years old, 90 years old. This is unacceptable. We have to decide which facilities to close. I talked about that. Which facilities to refurbish so we do not have these chronic problems.

We cannot do that with a budget that has been marked down \$1.4 billion by the House and the major construction part has been gutted by almost half.

Dr. CLANCY. I would say that we are hopeful for the moment that we may actually be able to resolve these air quality issues. I also want to point out that in terms of 40 miles from that CBOC is not part of the calculation any more, so that should offer more flexibility to the extent there are community providers.

The mobile unit, those are the plans we have right now. This will remain high on our agenda.

CIVILIAN BRAC PROPOSAL

Senator CAPITO. Thank you. It is definitely a problem. I would just briefly ask you, and this was my last question, in case I run out of time, since you were on it, on the facilities you mentioned excess properties, 336 buildings are empty. You said you need help with that.

How do we help you with that? It is not just budgetary. Is it statutory?

Secretary McDONALD. The President has put forward what I would call a “civilian BRAC.” In other words, the idea to take our facilities and have an up or down vote across the Federal Government. I just think that is a brilliant idea. We have to become more efficient.

I would suggest that it be passed and that we go at it.

MyVA REGIONS

Senator CAPITO. Okay. Let me ask you this. You mentioned these are the MyVA regions. Dr. Clancy mentioned VISNs. This is VA 101 for me. Are the VISNs gone?

Secretary McDONALD. What we have done is we have started a process where we are aligning the VISNs with those regions, and in doing that, we are taking a new look at the VISNs and seeing if there is an opportunity to reduce the number of VISNs.

The issue that we have right now, and this is a huge issue that reflects the actions we are taking in accountability, 91 percent of our medical centers have either a new medical center director or a new leadership team member.

We are really weak on leadership right now. We have new leaders in place. What I do not want to do is increase the spans of control so much that we take immature leaders or leaders with less experience and put them under more pressure.

What we are looking at right now is a modest reduction in the VISNs and an attempt to more align the VISNs to State boundaries.

Senator CAPITO. I noticed in our State of West Virginia, we are in the same MyVA. We are in three different VISNs, which makes no sense——

Secretary McDONALD. That is one of the things we want to fix.

CLARKSBURG VA FACILITY

Senator CAPITO. For a small State like ours. Again, the leadership issue. At the Clarksburg VA in Clarksburg, West Virginia, it has unfortunately lagged behind as one of the top people who have had the biggest wait times, and it just had a leadership change at that VA. Are you seeing anything yet? Too early to tell? Do you have anything to report there from Clarksburg?

Dr. CLANCY. I would be happy to follow up with you on that. I want to make a point for you and all of your colleagues, that we are tracking the excess and quality issues on an almost daily basis. I would be delighted to follow up, Senator.

[The requested information was not available.]

Senator CAPITO. Thank you for that.

Secretary McDONALD. In fact, we would be happy to invite any of you to come to our daily stand up that we do, where every morning we review the data and take action.

Senator CAPITO. All right. Thanks so much. Thank you.

Senator KIRK. Mr. Schatz.

VA/DOD ELECTRONIC HEALTH RECORDS INTEROPERABILITY

Senator SCHATZ. Thank you, Mr. Chairman. I know VA is working with the Department of Defense (DOD) so that the two can share servicemembers' medical records electronically, but progress, as you know, has been slow. The Government Accountability Office (GAO) specifically cited the lack of progress as an issue when it added VA to its 2015 high risk list.

According to GAO, "The two departments have engaged in a series of initiatives intended to achieve electronic health record interoperability but accomplishment of this goal has been continuously delayed and has yet to be realized. The ongoing lack of electronic health records' interoperability limits VA clinicians' ability to readily access information from DOD records," and so on.

What kind of progress are you going to be making and when can we expect for you to be off the GAO high risk list?

Secretary McDONALD. First of all, when I met with the head of GAO, I asked to be put on that list. We run the largest healthcare system in the country, and with the crises that have occurred, I thought it was appropriate that we are on the list. I think the transparency and visibility is important to improvement.

Second, we have made a lot of progress on the electronic health record. Also, I would like to offer to members of the subcommittee that we would be happy to come to your offices and demonstrate the interoperability of the DOD and VA record. I think once you see it, you will become much more conversant in the progress that has been made. Steph.

Mr. WARREN. Thank you, Mr. Secretary.

Senator SCHATZ. Very briefly, if you do not mind.

Mr. WARREN. Yes, sir. From an interoperability standpoint, we have been hitting on three levels. The first one is moving the data within the existing systems, and we share more data than any healthcare system in the Nation or in the world.

Our future is how do we get all the data in a single view, and that is the demonstration that the Secretary offered, where today you now can see all the VA data for any medical center and DOD data as well as third party provider data in the same screen. The data has been normalized, the providers can look at it and they can actually make decisions based upon a continuum of time in terms of that data.

Senator SCHATZ. What remains to be done?

Mr. WARREN. The two next things that need to happen is the viewer that chose that data is just for viewing, we are not able to actually go in and change the data. That is the next generation.

Senator SCHATZ. Is that a big technological or database breakthrough?

Mr. WARREN. It is two part. The first part is making sure there are common standards. Working with ONC, the Office of National Coordinator, to come up with national standards where there are no national standards. We work with DOD to put those standards in place.

Senator SCHATZ. Clinical standards or database?

Mr. WARREN. Data standards, so we actually have interoperability, we are using the same units, the same definitions. A lot of effort over the next couple of years to make sure the right standards are in place, and then we need to go through and convert the data to meet the standards, and then the second piece is to make sure the tools are there that shows the data at the same time, and we can start changing the data at either end.

Senator SCHATZ. What is the timeframe for all this?

Mr. WARREN. The enterprise health management platform, we are——

Senator KIRK. Let me step in here and deliver a threat that I have been saying to DOD, if they insist on having different standards, we will go with just the VA standards, that will force the two bureaucracies to agree on a common standard, and it will be a VA standard.

Secretary McDONALD. Thank you.

Mr. WARREN. Thank you for that, sir. A lot of strong work. If I can bring a third party in, the Office of National Coordinator does the standards for third party and private providers, and with the Access to Care Act, with more care going outside, it is not just the VA and DOD sharing, but how do we get the private providers in the same standard so their data can come in and be part of that continuum of care.

Senator SCHATZ. Start to finish—obviously, you will be able to use some of this work as you are moving along, but what is your total to completion?

Mr. WARREN. The enterprise health management platform will be at 33 sites by the end of the calendar year as a demo, again,

next generation, and then we will be adding capability on over the next 3 years until we phase out what we have today.

ALOHA VET CENTER, HAWAII

Senator SCHATZ. Thank you. Mr. Secretary, I want to ask very quickly about the ALOHA Vet Center on the Island of Oahu. Oahu has 70 percent of the State's population. I have talked to you a couple of times about it. This will double the availability of clinical services for about 1.2 million people and tens of thousands of veterans in the City and County of Honolulu. Can you give me an update?

Dr. CLANCY. This is going through the planning process right now. We expect it will be advertised late fall of this calendar year, and then the award will probably happen in the first quarter of fiscal year 2018. It is going to take time, but we are very, very excited about the access opportunities.

Senator SCHATZ. You said it would advertise this year and the award will go out in 2018? Did you mean to say 2016?

Dr. CLANCY. No. The actual final award and construction will happen in the first quarter of fiscal year 2018, and the construction will be complete in the last part of 2020.

Senator SCHATZ. Okay. My time has expired. I would like to understand why you go 2 years from advertising of the award to construction. Thank you, Mr. Chairman.

40-MILE DRIVING DISTANCE

Senator KIRK. My favorite Senator from Maine.

Senator COLLINS. Thank you very much, Mr. Chairman. Mr. Secretary, I, too, want to thank you for working with many of us on the 40-mile rule to change it from as the crow flies to actual driving distance. Like Senator Capito, I represent a State where as the crow flies and the driving distance are two very different things.

The VA still does not consider whether or not the type of care that the veteran needs is available at a VA facility that is within that 40-mile limit.

For example, in Western Maine, there is a VA Mobile Unit in Bingham, Maine that operates only 2 days a week. We are glad to have it. Obviously, it is nowhere near a full-fledged facility that can provide and meet the needs of our veterans.

That means veterans in Jackman, Maine could go to a hospital, a local hospital that is 35 miles away, still a distance, but much, much closer than going to the VA Hospital for care, or they could go to the local community health center right there in Jackman to get care, if the 40 miles were considered to be measured in terms of whether the service is actually available.

The service obviously is not available at a 2 day a week mobile clinic. It is available at the community health center and at a hospital that is 35 miles away.

These are not options available to our veterans in this area due to the interpretation of the 40-mile rule. Are you giving any thought to being more flexible in that area as well?

Secretary McDONALD. We are in the process of analyzing it and working with Members of Congress on what we discover. First of all, the idea that whether or not you can get care from your local

facility is actually written into the law, so it is not an interpretation. That was the way the law was written. If you would like it changed, you need to change the law.

Secondly, our initial calculation suggests that if we were to make that change, the minimum increase would be about \$10 billion a year, not over the 3-year period of the Choice Act, but a year, and it could be as high as \$40 billion a year, if we opened up that capability or that aperture for veterans.

We are in the process of looking at this, and what we want to do is come back to you with the boundaries on what we discovered and what our assumptions were, and have the discussion if that is a law change you would like to make.

Senator COLLINS. There may be some sort of middle ground here because in the case I gave you where the facility is not even a CBOC, it is a mobile unit that is open only 2 days a week, it just does not seem like a reasonable interpretation.

Secretary McDONALD. There is a middle ground point that we can take which is to in a sense change the geographic burden to give the Secretary more flexibility to allow people with a geographic burden of some kind to use the community care, and we are also working on that, and we will come back to you with the definition of that and how many people that will affect.

PROVIDER REIMBURSEMENT

Senator COLLINS. Thank you. I also want to associate myself with the comments of the Senator from Arkansas about slow payment to physicians and hospitals. This is a problem in my State as well.

The problem is that if the VA ultimately denies the claim, the hospital has missed the deadline for filing a claim for reimbursement to a secondary insurer such as Medicare. What happens is the healthcare provider ends up not getting paid at all.

I really hope that some energy will be put on this problem.

Secretary McDONALD. As I said, it is one of our most important strategies. We simply have to get it right.

ADULT DAY CARE

Senator COLLINS. Thank you. Finally, in the 10 seconds I have left, the VA in consultation with the National Association of State Veterans Homes began working on regulations that would govern adult day care, so there could be respite care for our veterans who are living at home but may be suffering from Alzheimer's or other dementias. That has been in process since October of 2008, far precedes you.

That is more than 6 years ago. For the record, since I am now out of time, I would ask you to give me an update. This would make such a difference to so many of our veterans and their family members, and it also would reduce nursing home costs and costs of the State veterans homes.

I really think this is something that should be finalized and should not have taken 6 years and still be pending.

Secretary McDONALD. We agree, and we will get back to you.

[The requested information was not available.]

Senator COLLINS. Thank you very much, Mr. Secretary.
 Senator KIRK. Senator Baldwin.

TOMAH VA MEDICAL FACILITY

Senator BALDWIN. Thank you, Mr. Chairman, and ranking member for this hearing today. Secretary McDonald, you noted in your testimony that the VA is really at a crossroads, and you struggle with significant challenges, including internal management controls, as well as the delivery of safe, appropriate care.

We have talked a number of times as I have with Dr. Clancy about how these two failures have had really tragic results at a particular medical hospital in Wisconsin, the Tomah VA medical facility.

I look forward to working with the members of this subcommittee on a number of steps we can take, including legislation and programmatic initiatives to correct these failures, to improve the quality of care that our veterans have earned.

Dr. Clancy, your clinical investigation into the Tomah VA, you have initial interim findings, and I know it is ongoing, but with regard to opioids prescribing, you found that Tomah was almost double the national average when it comes to rates of prescribing opioids and benzodiazepines concurrently, which is an unsafe practice that the VA's own clinical practice guidelines for opioid therapy warns against.

Jason Simcakoski is a Marine who was one of the patients prescribed both of these drugs and tragically passed away at the Tomah VA.

I want to start with asking you if you believe the VA has adequately managed the implementation of the clinical practice guidelines for opioid therapy at local VA medical centers.

Dr. CLANCY. I would say we made a good start and we have far more to go and that is what we are doing right now. The initial approach which predates both of us was to start at the network level and then go down to the facility, and as we have had a chance to brief you and your colleagues, this is now getting down to the individual clinician level, because we can do a much, much better job.

The irony, of course, is at that facility, Tomah, veterans are less likely to be on narcotics than in the network or the national average, but if they are on them, they are getting very high doses, and far more likely to be on benzodiazepines.

We are also looking at how we can start to bring this down to the individual patient level, and I think of that in two ways. One is that as you would expect, the initial efforts to reduce the use of opioids probably were most successful with those veterans struggling the least, and what we have now is a group of veterans with the most challenges with chronic pain and other complications.

The second is I think we desperately need to figure out what is the risk point at which someone transitions from taking narcotics sometimes, say for low back pain as an example. Is it a month, is it a couple of months? Where is that point where the risk level goes way up. I think that is where pain management intervention is most likely to be successful.

We are going to have to start to customize this much further, which is the whole point of the academic detailing initiative that has now been mandated and will be required for full implementation by the end of June.

Senator BALDWIN. I want to follow up on two points you just raised. One of the real problems at Tomah was obvious dangerous prescribing practices were considered within the bounds of acceptable care.

Question one is do you believe the current VA prescribing guidelines, which were last updated in 2010, are due for an update, and the second question, and it may have to wait until a second round, relates to driving these down to the patient level and involving patients and their families more actively in treatment protocols.

Dr. CLANCY. Two quick responses, given time, and I am happy to follow up with more. First, the guideline which was developed jointly by the Department of Defense and VA will be updated this year. They are going to be starting that process this fall. We know on average practice guidelines need to be updated about every 5 years, absent some kind of new breakthrough evidence. That is the first thing.

The second thing is we actually now require that all patients on narcotics actually sign an informed consent, and that is part of their medical record every year.

I would say that is a down payment on the kind of conversation you just referenced, and again, I am happy to follow up further.

[The requested information was not available.]

Senator BALDWIN. Thank you.

Senator KIRK. I would like to recognize our august vice chairwoman, Senator Mikulski.

Senator MIKULSKI. Thank you for calling me august. I feel like I have come in like a gust of air.

First of all, Mr. Chairman and Senator Tester, I would really like to congratulate you on the work you have been doing in VA MILCON, as you have been proceeding with due diligence, you have had the usual sense of bipartisan that has been characteristic of this subcommittee, and both of you have been fighting like hell for our veterans. As the vice chair of the full committee, I really want to thank you for the job, and will do what I can to get you a juicy allocation.

I would like to first of all say hello to Secretary McDonald and to his team here. I am going to engage in a bit of a Maryland question. First of all, Mr. McDonald, thank you for the job you have been doing, but you have a big job, and I think you are finding that under every rock is another rock.

IG REPORT ON VA HEALTHCARE IN MARYLAND

We found the same thing in Maryland. I asked the Inspector General of the VA to investigate claims that have come to my attention in my constituent area program, allegations that somebody had mouth cancer and was not properly tube fed, somebody who did not get mental health appointments and later committed suicide.

It was not me to finger point but to pinpoint, and the Inspector General came back with findings. Some are deeply troubling, that the facilities in Maryland did not follow the outpatient feeding policy, that they needed to comply with policies related to basic protocols on mental health services.

What the Inspector General did was come out with nine specific recommendations. Rather than taking the time of the subcommittee to read them, you know them, I have the report here now, could you comment on it, and could I have your commitment that you will do everything you can to follow up on the Inspector General's recommendations?

Secretary McDONALD. Yes, ma'am. I am a big fan of the Inspector General and the work the Inspector General does. When I was confirmed, I had about 100 IG investigations pending. I think we are down to something less than 70 now. They are still coming out, and most of them date to a year to 2 years ago. We take them very seriously because they are an opportunity to improve, and we remediate every single finding they come up with, and we will certainly do that in the case of those in Maryland.

Senator MIKULSKI. Did you want to say something, Dr. Clancy?

Dr. CLANCY. No, I would just add to exactly what the Secretary said, we will follow up on this very closely.

Senator MIKULSKI. Are you familiar with this?

Dr. CLANCY. Yes.

Senator MIKULSKI. Some of it is kind of surprising. First of all, I really do appreciate it and look forward to staying in touch on the follow up of the recommendations. They are not only for Maryland, but they are also for the rest of the country, like home feeding tube protocols, mental health response time protocols.

PERRY POINT MARYLAND COMMUNITY LIVING CENTER

The other is the question related to Choice and the implementation of Choice, and I have been an advocate of that. Have you all covered that in the questions?

Secretary McDONALD. Yes, ma'am, but go ahead and ask and we will fire away as quickly as we can. We also covered the replacement of a 155-bed community living center in Perry Point, Maryland, that has been stripped out of the House budget.

Senator MIKULSKI. You are replacing Perry Point?

Secretary McDONALD. Yes, ma'am. We had in our 2016 budget money to replace the 155-bed community living center in Perry Point, and that was stripped out of the House markup.

Senator MIKULSKI. Mr. Chairman, Mr. Vice Chair, I would like to talk with you about this. This is a facility that is really oriented to mental health, and it takes care of veterans with significant mental health challenges as well as Alzheimer's. Some parts of that building are pre-World War I. I would ask the subcommittee to come up, if the staff would, just to validate the need and necessity for the MILCON request. I think it is a compelling need, and we will talk about it.

Secretary McDONALD. We do, too.

CHOICE IMPLEMENTATION

Senator MIKULSKI. On the Choice card, I understand—it is a program I supported to shrink the waiting list. I understand of the 8.5 million veterans that have been issued Choice cards, less than 1 percent have been authorized care at non-VA facilities. Could you give us the status of the Choice program? Is it working the way we hoped? If it is not, is it bureaucratic delay? What is the issue here?

This was meant to be an opportunity for veterans. My Mountain County veterans, they are far away. The Eastern Shore, nine counties.

Secretary McDONALD. First, let me start, Senator, with the thought that community care is important to the future of VA. Currently today, even before the Choice Act, about 20 percent of our appointments are community care, meaning outside the VA. This is very important to us.

In the Choice Act, it has not yet worked the way we thought it would. We have not had the number of veterans go outside the VA system and use community care. What we have done is redefined the 40 miles, how you measure the 40 miles, it is driving distance now. We think that will double the number of veterans using the Choice card. We think that is a big improvement.

We are also looking at other improvements. We are doing marketing. We are doing websites. We have a public service ad. We are writing letters to veterans, making sure they understand the system because many of the cards went out over the holidays, and admittedly, a lot of people do not look at their mail over the holidays. Marketing was necessary.

We are looking at everything we can to maximize the impact of the Choice Act.

Senator MIKULSKI. Thank you. My time is up. I would just say to my colleagues the Choice Act does offer an opportunity, and perhaps you could use the 535 members of Congress throughout town halls and so on, newsletters, to help facilitate that. We hear the complaints. We would like to be able to at least share with them an opportunity.

Secretary McDONALD. That is a great idea.

Senator MIKULSKI. Not political, nothing political, but really about this opportunity, particularly for the primary care that this could provide.

Secretary McDONALD. We would love to join you in writing letters. We would also love to put a link on your website to the Choice Care website, anything we can do to increase communication. We would love to work with you on that.

Senator MIKULSKI. I think that would be fantastic.

Secretary McDONALD. All members.

Senator MIKULSKI. Thank you very much, Mr. Chairman, for letting me come in.

Senator KIRK. Dr. Cassidy.

HEPATITIS C TREATMENT

Senator CASSIDY. Dr. Clancy, Mr. McDonald. A friend of mine—I am a liver doctor. A friend of mine tells me that in the VA, the budget for treating Hepatitis C has already been exhausted, that

currently the only folks that can access the medicine used to clear Hep C are those with cirrhosis.

I suppose if you have cirrhosis, that is great. Really, you want to catch it before it gets to cirrhosis because once you have cirrhosis, you have a lifetime risk of cancer, that sort of thing.

First, any comments on that, and then I have a follow up.

Secretary McDONALD. As you are aware, Dr. Cassidy, Senator Cassidy, the treatment for Hepatitis C is very expensive, in the private sector it is roughly \$1,000.

Senator CASSIDY. A pill?

Secretary McDONALD. A pill. We get it for about \$650 a pill, so our treatment is cheaper, and arguably, we have the best protocols of any medical system. We do want to use it, but it has become a huge proportion of our budget.

As a result of that, we have asked for incremental money in the supplemental appropriation for Hepatitis C specifically, because I think it is a moral and ethical issue that we have the treatment, we know what to do, and we have patients that need it, because our population disproportionately has Hepatitis C, and we cannot use it.

Carolyn.

Dr. CLANCY. We are doing a far better job than the private sector in terms of screening and identifying veterans who have Hepatitis C and actually getting them identified and so forth. We have cure rates that is almost twice as high as the private sector.

Senator CASSIDY. It cannot be twice as high because it is about 90 percent in the private sector.

Dr. CLANCY. I mean the proportion of eligible veterans that have been cured. Sorry, I used the wrong terminology.

Senator CASSIDY. Let me ask just a follow up because I am going to learn here. The fellow told me listen, what we are told is send someone out to get the prescription from an outside provider, which would trigger the Choice Act fund of money, once they have the Rx, they can get their follow up in the VA.

I guess you alluded to this in an earlier part of your testimony. If the pot of money for the Choice Act is not being used for pharmaceuticals, we cannot say listen, no one is treating Hepatitis C in this community except the VA doc's and they have room in their slot, so let them access the pharmaceutical portion of the money. Is that correct? I am asking. I do not know.

Secretary McDONALD. Your point is correct, the inflexibility of moving money causes us to try to do different things with different pots of money. By sending someone out, we can use the Choice Care money and get them treated, whereas if they were internal, given our budget issues in pharmacy, we may not be able to treat them.

Senator CASSIDY. The pharmaceutical portion of the patient's care is also under the Choice Act, it is not just the doctor's visit, the surgery, whatever, it is also the pharmaceuticals?

Dr. CLANCY. What we are thinking through, and no final decisions have been made, although our doctors have very, very strong opinions because they have built up a tremendous capacity and expertise, is we would refer eligible veterans to a community provider but they would come back and get the medications from us, which

we think would be best for veterans and the taxpayers. It would be what we pay.

Senator CASSIDY. Getting back to your protocol, if you have a good protocol on whom to treat and whom not to treat, as a doc, I would not like that kind of discoordinated, well, we are going to send you out here because that is how we access this pool of money, but you are going to be followed up here because we have the better protocol for management.

Really, the decision regarding management is critical at its outset, if you will. Should we treat this person. Is there no way around that?

Dr. CLANCY. What we are trying to do is actually get as many veterans access to this life saving curative treatment as possible. This probably would not be the ideal design.

It would have some payoff, I think, of expanding the capacity in the private sector to take care of other patients with Hepatitis C, but it would require a lot of very close coordination back and forth between VA doc's and doc's in the community, and it would not work everywhere.

Senator CASSIDY. There is no way for the VA doc to access that Choice account for pharmaceuticals. It almost seems like we are trying to really Gerry rig—

Dr. CLANCY. Right now, that is not the case, and it gets back to the Secretary's point about inflexibility of budgets.

Senator CASSIDY. I have another question but I am out of time. I yield back.

Senator KIRK. Let me add on, with the drug, we would not need a liver transplant. As I have heard, it is about \$1,000 a pill. A liver transplant is about 300 grand. If we can avoid 300 grand by curing a veteran, then we are going to have much better outcomes.

Secretary McDONALD. Mr. Chairman, we agree.

Senator CASSIDY. If I may say, speaking now as a liver doctor, there are four stages with cirrhosis, the stage before, transplant is the fourth stage. You really want to catch it in that third stage. The third stage slides into the fourth.

If there is any way to expand coverage, and I am going over, and I thank you for your indulgence.

Senator MIKULSKI. Mr. Chairman, speaking as vice chair here—

Senator KIRK. Yes.

Senator MIKULSKI. First of all, there is a medical reason of staying with one place. In other words, the VA is your medical home. It seems sending them out is because of your inability to have flexibility and money.

Here is what I am suggesting to my leadership here. I would like to hear what is it that you need from us to give you the flexibility to do that, and number two, what are the impediments to do that? Do we have to go to authorizing, could we do language here, could we do something?

You are in a medical home, you actually get these pills at a cheaper price because you can buy in bulk.

Secretary McDONALD. Correct.

Senator MIKULSKI. Now there seems to be just bureaucratic rigidity maybe based on our law or something. With your capacity

and with the concurrence of Senator Cochran, I would like to talk with you about this. I think, Dr. Cassidy, you have identified an excellent point here.

Senator KIRK. Mr. Secretary, you look like you——

Secretary McDONALD. This is an important issue for Hep C because we are putting our doctors in the position of making decisions about somebody's life or death, whether they go to community care or our care.

This is an important issue for the subcommittee in general because once we decided the Choice program, we are allowing the veteran to choose where they go. I do not have the ability to move money from VA care to Choice care or from Choice care to VA care, yet we have introduced the invisible hand of Adam Smith, allowing the veteran to choose, and I do not have the ability to move money to care for him.

My biggest nightmare is that somebody goes for care and I have the money in the wrong pocket. You would not run a business this way.

Senator MIKULSKI. Can you help us?

Secretary McDONALD. Yes, ma'am. I would love to.

Senator MIKULSKI. I would like you to communicate with the chair and the ranking member who will then work with the leadership.

Secretary McDONALD. We have talked with both of them and they are both supportive.

Senator TESTER. I think Senator Cassidy brought up a great point and you have hit it right on the head. I think the challenge is going to be we are the problem. Congress is the problem on this. The challenge is going to be Congress pointing fingers at the Secretary saying you did not promote the Choice Act enough, and unless we keep that money in there, you will not promote that.

The truth is I think he needs the flexibility to transfer in both directions, depending on where the veteran demand is.

Senator KIRK. Senator Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman. Thank you to all of you for taking so much time with us today.

We have probably exhausted the subject of the implementation of the Choice program, but let me just add another wrinkle for you from our experience in Connecticut for you to ponder as you are thinking about how to implement this in a way that works.

I agree with Senator Tester, I may have a question on this. You certainly are going to have to prove that you have extended the reach of the Choice program to everyone that deserves to be under its umbrella before you are going to get the ability to transfer money.

40-MILE DRIVE RULE

Let me add another way in which that may happen to your laundry list. When the rule was 40 miles as the crow flies, it was largely meaningless in the State of Connecticut, small State, one VA.

When it moved to 40 miles by way of car travel, that helped, but it ignored one reality in Connecticut, which is probably not exclusive to Connecticut, I would bet it plays out in places like Chicago and Los Angeles, which is that often the 40-mile car ride brings

you into New York City, which is a route that veterans from many parts of Connecticut are not going to make and frankly should not make.

Because they are technically 40 miles away from a New York VA facility, they do not get access to VA Choice in their home town because they technically could get in their car and wait in traffic for 3 hours to try to get into Manhattan, Queens, or the Bronx.

I know this is tough to solve, because what you are essentially trying to figure out is adding the ways in which people commute to the very basic numbers that you have assigned based on mileage.

Is this something you are thinking about in terms of how you make sure that you are bringing as many people into the program as possible?

Secretary McDONALD. Yes, Senator Murphy. We are looking at something called the “geographic burden statement” in the Choice Act, and allowing the Secretary to have the flexibility to determine that geographic burden. That would solve the problem that you are describing.

We are working with the interpretation that currently exists. We are looking to reinterpret it, and we are going to work with you on that.

Senator MURPHY. Okay, good. Thank you very much. West Haven, our facility, first of all, it has been a really great facility for veterans in Connecticut, notwithstanding the wait times, backlogs, accounting scandals in other VAs. We have been able to get veterans in pretty much on time to West Haven. They have done a really phenomenal job there.

It is an old facility. It has an HVAC system that badly needs to be replaced. It still has ward style bedding in many parts of the hospital, absolutely no parking, which is a big deal in Connecticut.

Secretary McDONALD. It is a big deal everywhere.

CHOICE FUNDING FOR NON-RECURRING MAINTENANCE

Senator MURPHY. Big deal everywhere. If you do not get the ability to transfer dollars to the extent they are not used in VA Choice, where else do you go for these kinds of capital dollars? You are just going to have projects that simply are not going to get done, and dollars that are going to go unused, potentially, if you do not get this transfer authority.

Secretary McDONALD. That is exactly right. We have about 70-plus line items that money is not moveable from one to the other. As we talked about the House markup on the construction bill, virtually cut in half, eliminating many of the projects that are very important to us.

We do not have an alternative. It is ironic to me that Congress passes the laws telling us what benefits we need to execute to give the veterans. We are all for that, but if we do not get the money to do it, I cannot make the two match.

When I look back at what happened in 2014 to the VA, before I became Secretary, I would say it was a total mismatch of demand versus supply. You would not run a business that way. The way the agency has been run is working to a budget, not working to requirements, not working on what customer needs are. I am going

to change the Department. I am going to get us much more focused on veteran needs, but I need the wherewithal to do that. I cannot print the money myself.

There is a choice for Congress. The choice is decide some different benefit profile for the veteran or provide the money that is needed for the benefit profile you have already approved.

Senator MURPHY. Hallelujah. A long question, I will save it for the second round or for the record. Thank you, Mr. Chairman.

Senator KIRK. Senator Tester.

Senator TESTER. Just very quickly because I have to go. I have several questions for the record on billing, partnerships for mental health, and for Missoula CBOC. The whole committee does not need to hear this, but I thank you for your service, and we will look forward to the response to those. Thank you.

Senator KIRK. The Senator for all of King's Cove.

CHOICE FULLY INTEGRATED REIMBURSEMENT SYSTEM

Senator MURKOWSKI. Thank you, Mr. Chairman. Secretary, welcome to the subcommittee, Dr. Clancy. I appreciated the opportunity that we had to visit last week as you kind of walked us through some of the changes.

I was so appreciative that you took the time to visit with Katherine Gottlieb, who not only is an Alaska leader, but truly a national leader in innovation and working between systems, Federal systems, whether it is IHS and VA, but to really provide for an innovative level of care.

I am excited about this proposal. Mr. Chairman, ranking member, and to our august vice chair—she did not hear that—I do think at some point in time it would be wonderfully instructive for this subcommittee and those of us who are focused on the VA healthcare benefits for our veterans around the country to understand the very, very innovative models that we are utilizing in Alaska, where given large spaces and limited facilities, we are figuring out a partnering through systems, working through the IHS, working through our community health centers.

It is providing a level of service to our veterans that is immediate. We are breaking down some silos, and working with the Secretary here.

I think we can look to some models that may work in rural parts of our country that will provide the benefits that our veterans have so honorably earned, but in a way that is good care, good care. We call it "care closer to home."

I do not know about you, but when I am on the road, I am always sicker when I am away from home. If I can get back home where you have family and with our Native people and their Native foods being in a place that is comfortable.

It is something I would like to talk to the subcommittee about further and let you know what we are doing.

In that vein, Secretary, and Dr. Clancy, you can also jump in on this, we do have this partnering that is going on. I think the range of choices is good, but I also recognize that we are still offering range of choices within systems that still have their structure. I worry about moving of records and sharing of data, and really making sure that these separate rules within these differing programs

do not cause more confusion, and thus limit our veterans in terms of their abilities to access these.

Either Dr. Clancy or Secretary McDonald, can you give me any greater assurance as to how we are coming along with a more fully integrated system with this very unique model that we are seeing playing out in Alaska?

Secretary McDONALD. We have a lot of work to do together to get a single model that is integrated. Let me give you one example. We have five different ways that a veteran can get care in the community. Of those five different ways, each one has a different reimbursement profile.

When Senator Tester and I were in Montana and he organized a town hall meeting of providers, doctors, hospital systems, and so forth, everybody there wanted ARCH. They loved ARCH as a system. Well, ARCH pays Medicare Plus. Choice, PC3 paid Medicare, Medicare Minus. Everybody loves ARCH but they do not love the others.

To get to the right integrated system, we need to get all the providers on board. To get all the providers on board, we need to go to one integrated reimbursement system, one integrated system, and we are going to put that together and come to you, and hopefully get that passed, so that we can have no question to get the providers on board and the veterans have a place to go outside VA.

Senator MURKOWSKI. The sooner that can be done, I think it is to the veteran's benefit.

Secretary McDONALD. Absolutely.

Dr. CLANCY. The one point I would just add, it is working well, our sharing arrangements with the Tribal Health Services. Alaska is probably the most enthusiastic proponent and user of those agreements. We are thrilled about that, about \$10 million from VA has gone to those services.

MyVA REGIONAL REALIGNMENT

Senator MURKOWSKI. I appreciate that. Know that we want to work with you. I will just make one comment. We had an opportunity to sit down and talk about this regional realignment. I have to tell you, I am concerned. As I look at these divisions, it seems that we are getting bigger.

It looks like the territory that Alaska is in is almost identical to what the 9th Circuit U.S. Court of Appeals looks like. We have been fighting to break that up for a long time.

I am just sending the head's up to you that I am concerned that when you have one region that is covering thousands of miles, three different time zones, the concern that the regional offices will be able to provide for that level of care that our veterans expect, I am sending out the signals.

I have several different questions that I would like to ask. We have talked a little bit about how we are focusing on reducing the backlog, and I know it is always about numbers, but at the end of the day for the veteran, they want to know have you heard me, have you sat with me, what kind of care have you provided me.

I know my case workers in my offices back in Alaska work hard, and we are not pushing them to close out constituent cases, boom, boom, boom, and we are assessing you on that level.

Sometimes it is hard, but when we have one great success with our veterans, it makes our staff feel better, like they have really provided a service. I am concerned as we focus on we have to reduce the numbers, we are forgetting the customer service.

As we forget the customer service, we are forgetting not only the satisfaction to the veteran, but the satisfaction to the VA employee, who gets great personal satisfaction in knowing that they have provided a level of care. They fixed a vet's problem today.

If they cannot feel they are doing that, if they feel they are just processing numbers, the difficulty in recruiting and retention is going to continue, which means our backlog is going to continue.

You are nodding because I know you agree.

Secretary MCDONALD. We agree with you entirely. This is why we are all doing this. It is not because of the stock options you get from the Government. We are doing this because of the inspirational mission that we have of caring for those who have protected us.

Senator MURKOWSKI. We cannot lose sight of that.

Secretary MCDONALD. We cannot lose sight of that. It is more than numbers. It is the picture of the gentleman behind you. It is exactly the reason I gave out my cell phone number during the first national press conference in September, and I take calls every single day from veterans, and I listen to them. You have to keep that visceral empathy of what we are trying to do. It is all very personal.

Senator MURKOWSKI. Thank you for your dedication. Thank you, Mr. Chairman.

Senator KIRK. Senator Hoeven.

VETERANS ACCESS TO EXTENDED CARE LEGISLATION

Senator HOEVEN. Thank you, Mr. Chairman. Also, Secretary, thank you for being here today, appreciate it. I have visited with you before about legislation that I put forward, the Veterans Access to Extended Care.

It is all about making sure that we can encourage nursing homes to take VA reimbursement for veterans by eliminating the small business contracting requirements they are currently under when they take VA reimbursement, but they do not have to deal with when they take Medicare reimbursement.

That is a burden that really makes no sense for them, and they even have to undergo separate inspections, so there is a lot of red tape, a lot of compliance issues. Many nursing homes will not take that reimbursement.

I would just ask you to comment if you would on how you can help advance that legislation so we can get it put in place.

Secretary MCDONALD. We are very much in favor of it, so we would like to talk to everyone who is going to vote and make sure they vote in favor. We think that is the way to go.

We have to focus on veteran outcomes, veteran customer experiences, and there is just so much red tape that is getting in the way of it. In a sense, our people are trying to work in a system where they are prisoners of the system rather than working on meeting veterans' needs. We are very much in favor of the legislation you have described and we want to work with you on it.

Senator HOEVEN. Thank you, Mr. Secretary. That is very helpful. In fact, recently at a roundtable in my State, many nursing homes were represented there, and they said if we could get this passed, they would then look at taking VA reimbursement. I think it would be very helpful. I appreciate your willingness to help.

VETERANS ACCESS TO COMMUNITY CARE LEGISLATION

The second question I have for you is it is similar but it goes to the healthcare/medical care from local providers. You have touched on it here in a number of your responses.

I am a co-sponsor and others on the bill, it is similar, it is the Veterans Access to Community Care, and you have touched on that and some of the cost factors, but essentially the idea is to get veterans' care closer to home, when they have to go a long distance to a health center. They may have a CBOC.

For example, in my State, we have one VA health center. It is a very good health center. It covers North Dakota and most of Western Minnesota. They do a good job. It is a long way, 800-mile round trip from places like Williston, which I think is the fastest growing community under 50,000 in the country now, maybe over 50,000. I do not know. When they cannot get that service at a CBOC, we have real geographical issues here.

Your thoughts on what we can do to address it in a way that serves our veterans and then makes sense in terms of dollars and sense, to affordability.

Secretary McDONALD. I think job one is to really execute the redefinition of the 40-mile limit, and do that as quickly as possible so we can really determine how many people will want to use community care.

We really do not know today how many people want to use community care. We know the redefinition of the 40-mile limit will virtually double the number of veterans who will take advantage of it. That is what we think. We need to find that out.

Second, I want to redefine or reinterpret the geographic burden so that we have more flexibility, I have more flexibility to provide the ability for people to call it a geographic burden and go to community care.

The third thing we are looking at, which we talked about earlier, is whether or not we look at whether we define it as a VA facility that provide that service or a VA facility that does not. Opening up that aperture could potentially be extremely costly, as I said earlier. It could be \$10 billion a year to \$40 billion a year. Of course, the whole Choice Act, this part of it was \$10 billion over 3 years.

That is a conversation we will have to have. We need the numbers. We need some experience to be able to develop that algorithm.

Senator HOEVEN. I think that is really an important area, to figure out how to do this. Again, if they are within 40 miles of a VA health center, then that 40-mile rule works pretty well. If you have these really long geographic distances where they have a CBOC, it is a real problem because there is a big difference. If they have to have open heart surgery, sure, maybe that trip, I understand, and so do they.

There are a lot of situations where there are these services in between what a CBOC can provide and what a VA health center can provide, where it actually would be cost effective for the VA, too, because that veteran may have to travel one day, get the service the second day, travel the third day, and you are going to pay for both the travel and the accommodations as well as the service.

In the case of a very senior person, think about the burden of the travel. For a younger person who is working, they are not taking 3 days off work. It is not only about figuring out how to do this for the veteran, but I think it can be cost-effective for the VA, too, if we do it as you say, figure out the numbers and figure out how to do it. There is a difference between carte blanche and doing it in a way that makes sense.

Thanks for your help in this, and I look forward to working with you on it.

Senator KIRK. Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman. Mr. Secretary, good to see you again. Last year, I introduced legislation to expand the caregiver support services the VA offers and to make the full program available to veterans of all eras.

I am going to be reintroducing that legislation tomorrow. Senator Collins is my co-sponsor on that, and I want to work with you to make sure we strengthen the program and make sure it has the resources it needs to take on an additional workload.

I really was happy to see the Department requested a significant increase in funding for that program, and I have also asked for additional resources for the Department to hire more caregiver support coordinators.

I wanted to ask you today, do you know how many more caregiver support coordinators you think you will need over the next 2 years to support the current needs, and to take care of new veteran eras coming into this program.

Secretary McDONALD. Senator Murray, I do not know exactly, but I do know we are very supportive of the legislation you have written. We think pre-9/11 caregivers should get the same benefits post-9/11 get.

I have spent a lot of time with caregivers myself. They are the unsung heroes of our Nation. Many of them have to give up their jobs, and many of them have to purposely not take on work and not take on income because then they would fall out of the program.

It is a real conundrum for them, and it is life changing for families. We have to do this. We are eager to take it on and we are eager to hire the people we need.

I have been to several college campuses. There are people who want to join the VA to do this job. They are really eager to join.

Senator MURRAY. Good. If you could let us know what you think you are going to need over the next 2 years, that would be really helpful.

Secretary McDONALD. We will.

SPOKANE, WASHINGTON VA MEDICAL CENTER

Senator MURRAY. I think it is absolutely vital, so thank you. I also wanted to ask you about the Spokane VA Medical Center. As

you are very aware, the emergency room at the Spokane Medical Center has dramatically cut back its operations because of staffing problems.

The medical center has repeatedly pushed back the date to resume full time operations, and now I am being told it is not going to be until next fall.

The Spokane VA has also recently asked for its surgical complexity rating to be downgraded, and I am really concerned about that request and the potential impact on the access to care for our veterans in that region.

Last year, I asked Secretary Shinseki and Under Secretary Petzel whether there were any plans to reduce programs and services at the Spokane Medical Center, and they assured me there were not. Yet, we now see this facility being downgraded.

The medical center is not getting the job done, so I want to know what you are going to do to restore emergency services and surgical care for the veterans that rely on the Spokane VA.

Dr. CLANCY. One of the big challenges that we have had, Senator, and we have discussed this previously, is actually recruiting top-notch—

Senator MURRAY. I have been hearing that for 10 years.

Dr. CLANCY. Yes. I am meeting with the College of Emergency Physicians either next week or the week after that, and the American Legion also has some ideas about how we might work with some of the hospitals, and we have also raised the available salaries that can be paid to people there. Ultimately, if we cannot recruit top-notch talent, I think we are going to need to explore some kind of partnership between the Spokane facility and local hospitals vis-à-vis emergency care.

Senator MURRAY. This has been ongoing forever and it is not being resolved, and it is a huge issue for our Spokane veterans. I want to talk with you again, Mr. Secretary. We have to get this resolved however we do it.

Secretary McDONALD. While I know it has been going on forever, and we accept full responsibility for it, I have been to over a dozen medical schools recruiting doctors. I have been to the osteopathic convention recruiting doctors.

We are the canary in the coal mine. We are seeing the problem that exists in American medicine. We need more primary care doctors. We need more doctors who will live in rural areas. We need more mental health professionals. We are working extremely hard to do that, to find them, identify them, and convince them, and give them a monetary incentive to locate there.

We are going to continue to work very hard until we get that Spokane facility up and running.

WOMEN VETERANS ACCESS TO QUALITY CARE ACT

Senator MURRAY. I really appreciate it. One other question, I just have a few seconds left. Right now, the Veterans Affairs Committee is holding a hearing on VA services for women veterans. I want to stress how critically important it is for the VA to prepare now to meet the needs of a growing population of women veterans.

I was really pleased to work with Senator Heller to introduce the Women Veterans Access to Quality Care Act this year. That legis-

lation is going to go a long way to helping the VA provide safe, private healthcare for women.

VA already has a serious backlog in construction, but as the number of women veterans increase and as they age, there is going to be a need for more space dedicated to gender specific care.

I wanted to ask you what the VA is going to do to meet the treatment space for women veterans over the next 10 years.

Secretary McDONALD. Some of our budget that was cut dramatically in the House markup was slated for women's clinics. We are installing women's clinics in our facilities. We are hiring the gynecologists and other specialties that we need in order to staff those clinics.

To us, this is critically important. Eleven percent of veterans today are women. It is going to go up to 20 percent by 2017 or so. We have to get this done.

Many of our buildings, as I said earlier, are over 70 years old, some of them——

Senator MURRAY. They do not have private space for women.

Secretary McDONALD. And they have single gender bathrooms. We have to get this fixed. That is why our construction budget was as high as it was.

Senator MURRAY. Mr. Chairman, I am out of time. I will submit the rest of my questions, but I really appreciate that and I want to keep working with you on this.

Senator KIRK. Without objection.

DENVER MAJOR CONSTRUCTION PROJECT

Mr. Secretary, let me talk about the hippopotamus in the room, about Denver. You guys asked for \$5 billion to come from the Choice Act to help fix Denver. Where do we go from there in your view?

Secretary McDONALD. Where do we go in terms of?

Senator KIRK. What is your instinct for Denver?

Secretary McDONALD. Our instinct for Denver is to finish constructing the medical complex. We would use——

Senator KIRK. I would say finish constructing the medical complex under the supervision of the Army Corps of Engineers.

Secretary McDONALD. Yes, they are already on the project. They would complete the project with us. We plan to use the Army Corps of Engineers in the future for major construction projects.

Senator KIRK. I will make it simple for you, my position is Cory Gardner's position, to make sure that you work very closely with Senator Gardner. Thank you.

Secretary McDONALD. We agree.

Senator KIRK. Thank you.

Secretary McDONALD. In fact, the Deputy Secretary was out in Denver yesterday and has been there, I think, seven times since he has come into position.

Senator KIRK. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. Hopefully, three questions I can get in for this second round. I should follow up for the record also.

TOMAH, WISCONSIN FIELD HEARING

Dr. Clancy, you were at the field hearing in Tomah, Wisconsin, on March 30. I am a member of the Senate Homeland Security Committee that jointly held that with the House Veterans Affairs Committee.

We heard incredibly powerful testimony from family members of veterans who had lost their lives at the Tomah facility or after care there, as well as whistleblowers.

Now several months into this investigation, even at that hearing where we were hearing of more deaths that were unexplained that we had not heard before: in fact, I sent you another letter today, not based on testimony at that hearing but somebody who came up to me after the hearing and said, "my husband was treated there" and I have concerns related to all those that you have been hearing testimony about.

I just want to stress how important it is to have the investigation be sufficiently expanded to review those deaths, and I want your assurances that to the degree we can follow up on everyone that has been reported during the conduct of your investigation, that you will follow the evidence where it leads.

Dr. CLANCY. You have my full commitment; absolutely.

Senator BALDWIN. I appreciate that.

Senator KIRK. If the Senator would yield, let me just add I would associate my comments with Senator Baldwin, because a lot of Illinois veterans would use the Tomah facility. We want to make sure we fix the candy store, it was called.

Senator BALDWIN. Candyland.

Senator KIRK. Candyland; yes.

Senator BALDWIN. On the issue of proper treatment for pain, Secretary McDonald, not only do we have to crack down on inappropriate use of opioids and benzodiazepines, we have to increase the alternatives to narcotics for pain management. Veterans are calling for alternatives and complementary medicines, and treatments, pain treatment.

We are here in the appropriations committee. I want to ask you how the VA budget request supports the expansion of complementary and alternative medicine and wellness programs that would help veterans dealing with acute and chronic pain.

ALTERNATIVE MEDICINE AND WELLNESS PROGRAMS

Secretary McDONALD. As we look at VA opioid use, which as Dr. Clancy said, we track quite closely, it is moving down. The reason it is moving down is I think we are the largest user of alternative approaches in the country.

We have had tremendous success with acupuncture, with yoga, with electronic stimulation, and we want to continue that. Anything we can do to provide a different approach than opioid use, we want to do.

As I have been touring all of our facilities, I think I have visited about 125 so far, I am always inspired by those people who are teaching yoga. In one location not too long ago, there was an art instructor that was helping use art as a way to allow people to become themselves again without opioid use.

Equine therapy, we now use equine therapy in places like New Bedford, Massachusetts. These have been proven to be successful. Any data-based way we can prove a successful program, we want to do.

Dr. CLANCY. I would just add, Senator, that we are doing a lot of research in this area, trying again to understand which veterans and what characteristics will predict a better response to alternatives to narcotics, because that is very, very critical.

I think it gets back to the notion of an informed conversation between a clinician and a veteran, family, and so forth.

Senator BALDWIN. One final question. We were just talking about the health workforce at the VA. One of the things that I have certainly observed in rural medicine, for example, is if you received your training there, perhaps if you were born and raised in a rural environment, you are likely to make a commitment in your career to remaining there.

GRADUATE MEDICAL EDUCATION RESIDENCE POSITIONS

I think the same is very much true with regard to the VA. In the VA reform law that was passed last year, I authored a provision that was ultimately included that would increase by 1,500 over 5 years the number of GME residency positions.

It is my understanding that in this first year of implementation, 204 new resident positions were added. I would like briefly for you to give me a status update on the program's implementation.

Dr. CLANCY. Senator, first, thank you for those additional residency slots, because I think that is something that will keep paying dividends in terms of capacity. We did not actually think we could start residency positions until a year from this July because of the slow ramp-up. However, what we did was go to our existing partners and ask whether you have additional spaces, and that is where we got the 204 slots.

We do not know what the uptake has been, so for example, every year for the national match, it is kind of like the Dating Game, right, primary care slots tend to go unused, so we can get you a report on the 204. Match day was just a few weeks ago.

One of the other areas, to get back to your point about rural care, that we are working on, is trying to figure out how we work with facilities and communities, who would desperately like to do what you just described, but may not have the infrastructure, how do we do that to make sure we can get them the faculty support they need so the residents who are trained there get the proper education and so forth.

It is a very exciting opportunity, so thank you for that.

Secretary McDONALD. We are also pursuing osteopathic doctors, DOs. Osteopathic doctors tend to be more family or primary care physicians. They also tend to locate in rural areas because that is where the medical school is.

Today, less than 1 percent of our doctors in VA are DOs, so we are seeing if there is a way we can get more DOs. I spoke at their convention in order to get more people to locate in rural areas.

ADDITIONAL COMMITTEE QUESTIONS

Senator KIRK. I think we have pretty much beat this to death now. Let me call us to a close, and we will keep the record open until Tuesday, April 28, so members may have a chance to put in questions for the record.

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

QUESTION SUBMITTED TO HON. ROBERT A. McDONALD

QUESTION SUBMITTED BY SENATOR MARK KIRK

CHOICE ACT

Question. Your budget request included an interesting statement “VA is hearing directly from veterans and their representatives that they would prefer to get their care in VA facilities from the medical professionals they know and with whom they have relationships.” You also claimed the Choice Act will likely be underutilized and want to transfer money out of the program for other VA needs, which we find curious given the program is just getting started.

What data and facts are you using as the basis for these statements?

Answer. As of April 11, 2015, there were 43,971 authorizations for choice and 37,648 appointments scheduled. The Department of Veterans Affairs recognizes that early utilization of the Choice Program has not been as robust as expected. Based on input from all of our stakeholders—from veterans, Veterans Service Organizations, our employees, and Congress, we know that many veterans are frustrated with the Choice Program and these frustrations and confusion are leading to lower use of Choice. However, we have been eagerly seeking feedback on the program from these stakeholders and we are working diligently to address any challenges that may be contributing to the low utilization.

QUESTIONS SUBMITTED BY SENATOR JON TESTER

BUILDING CAPACITY

Question. In this budget, the VA assumes a cost shift of \$452 million next fiscal year from the discretionary VHA program for non-VA care to the new Choice Act program. However, it’s becoming clear that the utilization of the Choice Program isn’t as high as expected, at least not at this point. Meanwhile, VA’s traditional non-VA care programs are seeing higher utilization rates than at this same time last year. With no flexibility to move Choice Act funds and given the VA’s assumptions in this proposed budget, are we setting up the VHA for a shortfall should the current utilization rates hold?

Answer. We continue to closely monitor usage of the Choice Program and non-VA care and will provide additional information when we submit our letter on the sufficiency of funds in the three medical care advance appropriations for fiscal year 2016, as required by the Veterans Health Care Budget Reform and Transparency Act of 2009.

AGENCY COLLABORATIONS

Question. I know that a number of VSOs have urged the VA to work more closely with other agencies in the delivery of care. One example is stronger partnerships with the Department of Health and Human Services to expand mental health services through community mental health centers. Can you speak more to this concept and how it could expand the reach of mental health services for veterans and their families?

Answer. Through the Interagency Task Force (ITF) on Service Member and Veterans Mental Health and several specific initiatives such as the Cross-Agency Priority Goal on Service Members and Veterans Mental Health (CAP Goal), VA has worked closely with the Department of Health and Human Services as well as the Department of Defense on a number of mental health efforts over the past several years. For example, VA mental health experts have participated in Policy Academies conducted by the Substance Abuse and Mental Health Services Administration, at which State-level plans are developed for community mental health programs to im-

prove services for veterans and their families. VA and DOD also jointly developed a comprehensive curriculum on military cultural competence that is available online and provides free continuing education credits to healthcare providers across the Government and in the community (i.e. to non-government providers who may serve servicemembers, veterans and family members as a portion of their patient population). Efforts are underway to more broadly disseminate this course and other resources to community mental health providers.

VET CENTERS

Question. What is the VA's long-term strategy for mobile vet centers?

Answer. VHA's Readjustment Counseling Service (RCS) is currently authorized a fleet of 80 Mobile Vet Centers (MVC) that are designed to extend the reach of Vet Center services by bringing focused outreach, direct service provision, and referral services to communities that do not meet the requirements for a "brick and mortar" Vet Center, but where there are veterans, servicemembers, and families in need of services. In many instances, these communities are distant from existing services and are considered rural or highly rural.

Each MVC includes confidential counseling space for direct service provision as well as a state-of-the-art satellite communications package that includes fully encrypted tele-conferencing equipment, access to all VA systems, and connectivity to emergency response systems. Vet Center staff members regularly collaborate with VA partners to create a single VA Footprint at events to ensure access to all available VA services and benefits. The placement of these vehicles is designed to cover a national network of designated Veterans Service Areas (VSA) that collectively covers every county in the continental United States, Hawaii, and Puerto Rico.

MVC staff, in collaboration with local and Regional RCS Leadership, will develop and implement a focused access plan to ensure veterans, servicemembers, and their families within their VSA have access to Vet Center and other VA services.

Each access plan will be considered a living document to be reviewed and updated on a biannual basis to ensure it is consistent with the needs of the veteran and servicemember population within the VSA. These plans will take into account the RCS goal of increasing MVC participation in events by 15 percent over the previous fiscal year.

QUESTIONS SUBMITTED BY SENATOR TOM UDALL

GENERAL ACCOUNTABILITY

Question. New Mexico's VA Hospital is within the same region as Phoenix, and experienced some of the same scheduling abuses. I want to make sure that headquarters does not forget about the issues in New Mexico as well. I have worked closely with the Inspector General's office to refer many very serious complaints and support his investigation. Given the unacceptable nature of recent VA problems, I'm glad we have new leadership at the VA, both in Washington and in New Mexico. Will you give me your commitment to work to restore a culture of high standards and accountability at the VA including in New Mexico?

Answer. Yes. VA's goal continues to be strengthening its culture of accountability and putting renewed focus on employee-led, veteran-centric change. Improvements in workforce culture, with a focus on ICARE values (integrity, commitment, advocacy, respect, and excellence), will allow VA to address issues as they arise, rather than necessitating employee termination following repeated and/or pervasive poor behavior.

POLYTRAUMA AND TRAVEL

Question. The VHA's budget mentions that TBI and polytrauma are major concerns for veterans who served in Iraq and Afghanistan. I couldn't agree more. However, I am concerned about the large distances many veterans, especially those in the west, have to travel to visit a polytrauma rehabilitation center or a polytrauma network site. These facilities offer advance care for our veterans, and unfortunately, for New Mexicans, the closest sites are far away in neighboring States. Can you tell me what the VHA's plan are for expanding access to polytrauma care, and what it would cost to increase the coverage in the western United States?

Answer. To improve access to specialized rehabilitation care for Veterans with TBI and Polytrauma who live in the western United States, VHA has expanded the Polytrauma System of Care, increased utilization of telehealth, and engaged community providers to partner in healthcare delivery for veterans. VHA deployed a network of 2 Polytrauma Rehabilitation Centers, 5 Polytrauma Network Sites, and 12

Polytrauma Support Clinic Teams to provide comprehensive TBI rehabilitation services in the western United States. Additionally, 18 Polytrauma Points of Contact sites offer a more limited range of TBI services with specialized providers.

In fiscal year 2014, VA facilities in Veterans Integrated Service Networks (VISN) 18-22 provided care for 12,721 veterans with TBI and completed 40,895 visits. This represents approximately 24 percent of the TBI rehabilitation workload reported nationally. Overall, the TBI rehabilitation workload reported in VISNs 18-22 is in line with the distribution of programming assets through the Polytrauma System of Care.

At the same time, VA pursues new opportunities to improve access to specialized rehabilitation care for veterans with TBI and Polytrauma. These include:

- Expanding medical rehabilitation services: VA added two Polytrauma Support Clinic Teams in Nevada and Montana and hired new staff to augment existing programs. For example, the El Paso VA added three new providers with dedicated time in polytrauma/TBI care. Overall, the number of rehabilitation specialists working in VISNs 18–22 grew by 7.5 percent in fiscal year 2014 from fiscal year 2013.

While deploying additional rehabilitation assets continues to be one of the avenues for improving coverage, VA has to balance this with the rather low demand for services across large geographical areas.

Leveraging technology, specifically telehealth: This provides an effective means of reaching more patients in remote areas. TBI and Polytrauma telehealth services reached 57 percent more patients in fiscal year 2014 than in fiscal year 2013. VA is working to bypass some of the existing difficulties with the quality of broadband in rural areas by leveraging new technologies such as the newly released “CVT Patient Tablet,” which facilitates broadband videoconferencing between the veteran’s home and the provider, who may be located in a different State or VISN.

Partnering with community providers to deliver healthcare services: While VA has used fee-based care successfully in the past, the new processes developed as a result of the Choice Act provide clarity and facility to these partnerships. VA is also reaching out to community partners to provide education and training using VA-developed materials with the goal of supporting continuity of services. The cost of expanding medical rehabilitation services in VISNs 18–22 could include increased staffing at the 18 Polytrauma Point of Contact sites that do not have fully staffed TBI/Polytrauma teams. To fund additional TBI/Polytrauma teams at these sites would cost approximately \$550,000 per year (salary dollars for 3.5 staff per site), for a total of \$9,900,000 annually. The cost of increasing telehealth services and community partnerships is more difficult to calculate at this time as technology evolves and community partnerships mature.

VA continues to work to increase access to specialized TBI and Polytrauma care by leveraging assets, technology, and community partners and balancing those with veterans’ needs in communities across the western United States.

CHOICE ACT

Question. One concern I have heard about the veterans choice act is that the VHA cannot guarantee that the veteran will receive the same quality of care that they would at a veterans hospital or clinic. How is the VHA working to ensure that veterans receive quality care when they make use of outside medical care as authorized in the veteran’s choice act?

Answer. VHA works to maintain quality oversight of all purchased care from the community related to certain standards, including, but not limited to, credentialing, access to care/timeliness, patient safety, and patient satisfaction. For example, to increase governance and oversight of quality and patient safety in the field for VA Care in the Community, the Choice Program has adopted a multi-committee structure focusing on Quality Oversight and Safety and Patient Quality and Safety.

RURAL HEALTH

Question. Based on the budget requirements and the VHA’s experience, which would be the best way to improve access to quality care. An expanded fee for service program, or a program which aims to recruit and retain rural physicians and nurses at rural CBOCs and which helps to expand telehealth And which would be most cost-effective for the American taxpayer?

Answer. VA is committed to delivering timely and high quality healthcare to our Nation’s veterans, and the ultimate goal is to align our capacity with the veterans’ needs and preferences. Therefore, the most valuable measures we use to understand an individual’s ability to access our system are the perceptions and opinions of our

veteran patients. This requires balancing our fee for service program, recruiting and retaining the best medical professionals, and using innovative technologies such as telehealth to increase access to care for veterans.

FEDERAL IT REFORM

Question. Describe the role of the Veterans Health Administration's Chief Information Officer (CIO) in the development and oversight of the IT budget for the Veterans Health Administration. How is the CIO involved in the decision to make an IT investment, determine its scope, oversee its contract, and oversee continued operation and maintenance?

Answer. The VHA CIO prepares annual IT resources budget requests that are approved by the Undersecretary for Health and then through the Information Technology Leadership Board (ITLB), before being presented to the Secretary. The VA ITLB is the body that recommends the annual budget request to the Secretary. As such, with advice from staff, the VA CIO works with VHA IT personnel to determine project scope and subsequent contractual efforts needed to undertake development efforts to provide needed technological solutions to our business partners in the Department (VHA, the other Administrations, and Staff Offices). The VA CIO plays a key role in developing the annual budget submission, as well as being the single point of authority for IT in VA, is the sole individual for overseeing continued operation and maintenance of deployed IT capability in the Department.

Question. Describe the existing authorities, organizational structure, and reporting relationship of the Chief Information Officer. Note and explain any variance from that prescribed in the newly-enacted Federal Information Technology and Acquisition Reform Act of 2014 (FITARA, Public Law 113-291) for the above.

Answer. There is no variance between the requirements set forth in the Act and the activities that the VA CIO has been performing, subsequent to 2009's consolidation of IT into a centralized account. The VA CIO is the sole authority for all matters related to IT in VA and reports directly to the Secretary for Veterans Affairs (SecVA).

VA's CIO:

- Approves agency's IT budget requests
- Certifies that IT investments adequately implement incremental development
- Confirms that all requested IT positions meet ongoing requirements
- Reviews and approves VA's contracts and funds reprogramming requests for IT
- Directs IT capital planning and investment review process and certifies the accuracy and risks associated with the investments
- Administers the development of an integrated IT infrastructure
- Promotes efficient and effective design and operation of information resource management processes

Question. According to the Office of Personnel Management, 46 percent of the more than 80,000 Federal IT workers are 50 years of age or older, and more than 10 percent are 60 or older. Just 4 percent of the Federal IT workforce is under 30 years of age. Does the Veterans Health Administration have such demographic imbalances? How is it addressing them?

Answer. The Office of Information and Technology (OI&T) within the Department of Veterans Affairs (VA) reflects similar percentages. The attached table displays the following statistics. OI&T has a total employee population of 7,916, which includes all IT workers and those that provide support to the IT workforce. OI&T has 145 (1.8 percent of the total) employees under age 30; 1,290 (16.3 percent) employees between ages 30 and 39; 2,314 (29.2 percent) employees between ages 40 and 49; 3,087 (39.0 percent) employees between ages 50 and 59; and 1,080 (13.6 percent) employees over age 60. Percentages for IT employees (those with occupational specialty 2210) are very similar and near identical to the entire population of OI&T.

We are refreshing our existing Human Capital Management (HCM) Strategic Plan to specifically address this topic. We are analyzing existing trends within industry as well as the rest of the Federal Government. We are leveraging our existing contracted consultants to gain insight on how the entire Federal Government is going to address this changing workforce. For example, OI&T is examining phased retirement, an initiative that for which the Office of Personnel Management (OPM) issued a final rule last year. If implemented, employees who are eligible for retirement would continue to work part time while drawing a portion of their retirement. This program could aid OI&T succession planning efforts.

TABLE

Age Demographic	Total OI&T Workforce: 7,916	IT Employees in occupational specialty 2210 (Computer Specialist): 6,661
Under 30	145 (1.8 percent)	118 (1.8 percent)
30–39	1290 (16.3 percent)	1107 (16.7 percent)
40–49	2314 (29.2 percent)	1962 (29.5 percent)
50–59	3087 (39.0 percent)	2571 (38.6 percent)
Over 60	1080 (13.6 percent)	903 (13.6 percent)

[For further information, see the VA document “Office of Information and Technology: Human Capital Strategic Plan 2014–2022.”]

Question. How much of the Veterans Health Administration’s budget goes to Demonstration, Modernization, and Enhancement of IT systems as opposed to supporting existing and ongoing programs and infrastructure? How has this changed in the last 5 years?

Answer. As mentioned in the opening remarks, all VHA IT expenditures are funded by the central IT Appropriation, which is administered by the Office of Information Technology (OIT). The Office of Information Technology Development, Modernization, and Enhancement (DME) and Operation and Maintenance (OM) budget for the 5 years from fiscal year 2012 through fiscal year 2016 is in the table below:

TABLE

(Dollars in Million)	Fiscal Year 2012	Fiscal Year 2013	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016 Request
Total DME	\$580.358	\$517.921	\$495.291	\$548.335	\$504.743
Total OM	\$1,616.018	\$1,834.523	\$2,181.653	\$2,316.009	\$2,512.863

Question. What are the 10 highest priority IT investment projects that are under development in the Veterans Health Administration? Of these, which ones are being developed using an “agile” or incremental approach, such as delivering working functionality in smaller increments and completing initial deployment to end-users in short, 6-month timeframes?

Answer. VA develops hundreds of IT projects under several categories (such as Access to Health Care, Eliminating the Backlog, Eliminating Veteran Homelessness, and Information Security, to name a few). Each Administration and business function within VA has its respective priorities in support of the overall VA mission. The list provided below represents VA’s priorities in IT development across a broad range of Department goals.

Health: Vista Evolution (including Pharmacy, Laboratory, Medical Appointment Scheduling System, and Enterprise Health Management Platform (eHMP)), Mental Health, Surgery, Bar Code, Enrollment Customer Enhancements, Purchased Care, Medical Care Collection Funds, Genomic Informatics System for Integrative Science (GenISIS), Virtual Lifetime Electronic Record (VLER), Mobile Applications

Benefits: VBMS, eBenefits, Customer Relationship Management

Memorial and Corporate Products: HRIS/HR Smart, PIV Enhancements, VATAS Enhancements, Memorial and Benefits Management System (MBMS)

Over the past several years, VA has become a leader among Government agencies in implementing agile development. In fact, the U.S. Government Accountability Office (GAO) Report 14–361 indicated that VA was the only agency to implement agile development methodology fully. PMAS is the disciplined, data-driven approach VA utilizes to support on-time delivery of IT capabilities. VA is developing each of the projects in this list using an agile development approach.

Question. To ensure that steady state investments continue to meet agency needs, OMB has a longstanding policy for agencies to annually review, evaluate, and report on their legacy IT infrastructure through Operational Assessments. What Operational Assessments have you conducted and what were the results?

Answer. VA’s OIT Service Delivery and Engineering (SDE) office has conducted an annual Operational Analysis (OA) based on OMB criteria for its major steady-state investments, which are Medical IT Support, Benefits IT Support, and Enterprise IT Support. These investments have performed within acceptable variances, or

higher than performance metric thresholds. Notably, the average availability of major systems has consistently been above 99 percent.

Question. What are the 10 oldest IT systems or infrastructures in the Veterans Health Administration? How old are they? Would it be cost-effective to replace them with newer IT investments?

Answer. The table below describes 18 VA systems that leverage legacy technology (i.e., common business-oriented language (COBOL) software or mainframe hardware) and are potential candidates for replacement. While the VA does not track the exact deployment date for legacy systems, many of the listed systems have been active for 25 years or more. Over the last year, VA has been developing a comprehensive divestiture process that will be utilized to assess system value based on a variety of technical and business criteria to determine if legacy systems should be divested or maintained. Implementation of this process is anticipated to begin in fiscal year 2016.

Veterans Health Information Systems and Technology Architecture (VistA) is a system containing over 100 individual component applications (Pharmacy, Lab, Imaging, etc.) with unique instances at data centers across the Nation. VistA includes the Computerized Patient Records System (CPRS). VA is placing special emphasis on developing and deploying a modern version (VistA Evolution) to replace and upgrade VistA.

Table

VASI Id	System Acronym	System Name	Parent Organization	Organization
1277	FMS	Financial Management System	OM	Office of Finance
1174	DSS	Decision Support System	OM	Office of Finance
1423	MPCR	Monthly Program Cost Report	OM	Office of Finance
1160	CCS	Credit Card System	OM	Office of Finance
1712	VETSNET	Veteran Service Network	VBA	Veterans Benefits Administration
1352	IPS	Insurance Payment System	VBA	Veterans Benefits Administration
1053	BIRLS	Beneficiary Identification Record Locator System	VBA	Office of the Deputy Under Secretary for Disability Assistance
1094	CH 1606	Chapter 1606—Montgomery GI Bill Selected Reserve—Benefits Payment System	VBA	Veterans Benefits Administration
1196	ESS	Enterprise Self Service	VBA	Veterans Benefits Administration
1145	COVERS	Control of Veterans Records System	VBA	Veterans Benefits Administration
1099	CH 30	Chapter 30—Montgomery GI Bill Active Duty Benefits	VBA	Veterans Benefits Administration
1102	CH 31	Chapter 31—Vocational Rehabilitation and Counsel	VBA	Veterans Benefits Administration
1973	VistA	Veterans Health Information Systems and Technology Architecture	VHA	Veterans Health Administration
1830	PAID	VistA—Personnel and Accounting Integrated Data	VHA	VHA Office of the Principal Deputy Under Secretary for Health
1126	CNH	Community Nursing Home	VHA	VHA Office Patient Care Services
1085	FEE	Central Fee System	VHA	VHA Chief Business Office
1909	DM2	Debt Management System	VHA	Veterans Health Administration
1056	BDN	Benefits Delivery Network	VBA	Office of the Deputy Under Secretary for Disability Assistance

Question. How does the Veterans Health Administration's IT governance process allow for the Veterans Health Administration to terminate or "off ramp" IT investments that are critically over budget, over schedule, or failing to meet performance goals? Similarly, how does the Veterans Health Administration's IT governance process allow for the Veterans Health Administration to replace or "on-ramp" new solutions after terminating a failing IT investment?

Answer. Although IT governance is led by the Office of Information and Technology (OI&T), VHA recognizes the need for complementary VHA IT governance to inform OI&T and to allow for proper investment oversight by the customer/con-

sumer. As such, VHA has recently revamped the VHA IT decisionmaking process in support of VHA governance. It was recognized that a high level of management, structure, and compliance is necessary to carry out a successful business and/or IT program. Because better management, awareness, and decision-making required a portfolio/capability construct that is comprehensive, decisionmaking is now based on a comparative review of IT investment alignments against VHA's strategy and objectives—such as those endorsed in VHA's Blueprint for Excellence.

Likewise to support this governance approach, VHA established an investment review board whose responsibilities include regular program reviews with a focus on performance and business outcomes. Additionally, the governance process empowers capability management boards (CMB), comprised of key VHA leaders and field clinicians, to prioritize programs, using business criteria, for IT investment funding. These boards also provide a business council to review funded IT programs and make sure they are meeting their requirements, executing properly, and doing so within the approved schedule. Finally, the VHA IT governance process provides the forum for discussion to occur with OI&T and VHA for ceasing poorly performing projects and replacing them with other “in the queue” VHA IT priority needs.

OIT has implemented the Program Management Accountability System, or PMAS, to monitor the progress of projects. Project efforts are divided into increments, each of which delivers specified functionality to OIT's business partners in 6 months or less. PMAS ensures the readiness of increments to be successful through its milestone review process and the performance of increments to deliver on time and on budget through its risk management process. If a project misses three on-time increment deliveries it must submit to a Closure Review ensuring that if projects fail, they do “fail fast,” reducing the drain on IT resources. If a project is closed out, resources then become available to reassign. VA OIT prioritizes requirements that do not otherwise have funding (“unfunded requirements,” or UFRs). The prioritization is conducted within the context of the IT governance process—that is, the prioritization that is developed is approved through the IT Leadership Board and the Deputy Secretary for VA. Resources that become available are assigned to UFRs in order of their prioritization, which will “on ramp” new projects. One of the requirements for an effort to be considered in the UFR prioritization process is that it is ready to execute if funding becomes available.

Question. What IT projects has the Veterans Health Administration decommissioned in the last year? What are the Veterans Health Administration's plans to decommission IT projects this year?

Answer. VA is developing a divestiture process that will be used to formally guide divestiture decisions and actions moving forward and is continuing to strengthen governance in place to be effective. Systems recently decommissioned are listed below.

During fiscal year 2015/2016 the following systems/applications are being considered for retirement.

1. Titus Toolbar
2. Existing AV system
3. Region 1 Remedy Help Desk system
4. Region 3 Remedy Help Desk system
5. Region 4 Serena Help Desk system
6. Tuscaloosa Remedy Help Desk system
7. NCA Remedy
8. FSC System Center Service Manager

Table

VASI Id	System Acronym	System Name	Parent Organization	Organization
1141	CMIS	Construction Management Information System	OALC	Office of Construction and Facilities Management
1959	VBRS	Veterans Benefits Reference System	VBA	Veterans Benefits Administration
1362	INP	International Payments	VBA	Veterans Benefits Administration
1708	VCC	Veteran Call Center	VBA	Veterans Benefits Administration
1389	LACAS	License and Certification Approval System	VBA	Veterans Benefits Administration
	SMART	SMART Certification and Accreditation Tool	OI&T	Office of Information and Technology
1104	FET	Chapter 33—Front End Tool	VBA	Veterans Benefits Administration

Table—Continued

VASI Id	System Acronym	System Name	Parent Organization	Organization
1130	CAPRI	Compensation and Pension Record Interchange	VHA	Veterans Health Administration
1605	SCIDO	Spinal Cord Injury and Disorders Outcomes	VHA	Veterans Health Administration

Question. The newly-enacted Federal Information Technology and Acquisition Reform Act of 2014 (FITARA, Public Law 113–291) directs CIOs to conduct annual reviews of their IT portfolio. Please describe the Veterans Health Administration’s efforts to identify and reduce wasteful, low-value or duplicative information technology (IT) investments as part of these portfolio reviews.

Answer. Each year, OIT conducts a zero-based build of its IT portfolio as it builds the IT budget request. By its nature, by building from the “bottom up” each year, all items in the IT portfolio are assessed regarding their support of OIT’s requirement to provide VA business elements with the technological tools needed for their success. Demand for IT solutions exceeds the resources available, so OIT’s budget build necessarily (a) focuses on the highest priority items first, and (b) works to maximize the efficiency of all elements in the IT portfolio. Put another way, maximizing the efficiency means working to eliminate redundant, wasteful, and low value efforts so that the IT portfolio, as a whole, provides the best utilization of scarce resources. This “zero-based” build is reviewed through the IT governance process where all of OIT’s VA stakeholders (VHA, VBA, NCA, and staff offices) are represented and can weigh in on the budget build. The VA CIO chairs the IT Leadership Board that runs the IT governance process that reviews the IT budget. As VA is unique in the Federal Government in having a separate appropriation that funds all of OIT, the IT governance process allows the CIO to review the entire IT portfolio annually as a result of building the IT budget request. Once an appropriation is received, review of execution occurs. While this isn’t an annual process but rather an ongoing one, it nonetheless also works to identify development efforts that are not performing as intended. Those resources are recaptured and then applied to other projects within the constraints of enacted appropriation law.

Question. In 2011, the Office of Management and Budget (OMB) issued a “Cloud First” policy that required agency Chief Information Officers to implement a cloud-based service whenever there was a secure, reliable, and cost-effective option. How many of the Veterans Health Administration’s IT investments are cloud-based services (Infrastructure as a Service, Platform as a Service, Software as a Service, etc.)? What percentage of the Veterans Health Administration’s overall IT investments are cloud-based services? How has this changed since 2011?

Answer. Every hosting decision considered cloud computing as an option for deployment. It is estimated that 15 of over 200 Veterans Health Administration’s IT investments involve some proportion of cloud-based services (Infrastructure as a Service, Platform as a Service, Software as a Service, etc.). About 5 percent of the Veterans Health Administration’s overall IT investments involve some cloud-based services. The percentage has roughly tripled since 2011.

Question. VA CIO Stephen Warren testified to Congress in November 2014 that the VA was directing an additional \$60 million to its information security efforts in fiscal year 2015. How is the Veterans Health Administration leveraging its internal information security resources to protect against breaches or leaks that could disclose sensitive and personally identifiable information? Does the Veterans Health Administration currently use digital rights management or other content-centric tools to protect such information?

Answer. VA’s Continuous Readiness in Information Security Program (CRISP) is the Department’s guiding initiative designed to foster a security-conscious culture and establishing a stronger information security posture across the enterprise. As has been recognized by the Office of Inspector General (OIG), VA has used CRISP to make significant progress towards addressing findings of material weakness in recent years. VA recently established a dedicated CRISP Program Management Office, which allows VA to allocate full-time staff members to maintaining an effective risk-based security program and preparing for annual OIG audits.

CRISP represents a cultural change that is necessary for VA to achieve adequate protection of veteran and other sensitive information. Thus, its success is largely de-

terminated by the entire community of VA employees, business partners, and contractors adhering to security policies to preserve the trusted relationship that VA has with veterans. CRISP program success includes, among others, the following:

- Annual mandatory information security training is VA-wide for all employees and contractors and is strictly monitored and enforced.
- VA is performing onsite information security compliance validation across the enterprise.
- VA has initiated a project to identify unauthorized software on the VA network and remove, update, or replace the software as appropriate.
- Scanning of all known devices for outdated software patches, removal of software strictly prohibited by VA is being enforced with additional resources that were allocated to the CRISP Program.

In addition, VA utilizes a “defense in depth” approach to protecting its information from internal and external risks. This approach includes administrative, technical, and physical security controls, which are implemented throughout VA systems. If one control fails, others are designed to provide protection so that VA data is not placed at risk. VA has also implemented a continuous monitoring capability that allows VA to automatically monitor its systems for threats and vulnerabilities.

VA has implemented rights management software (RMS) to protect veteran information. VA also provides users with the capability to use their PIV cards to sign and encrypt emails and documents.

VA does not use digital rights management or other content-centric tools. However, VA has implemented rights management software (RMS) which allows information and documents to be protected and controlled, including an inability to be forwarded, printed, or saved. VA also provides users with the capability to digitally control content through the use of PIV cards to sign and encrypt emails and documents.

SUBCOMMITTEE RECESS

Senator KIRK. I call it adjourned.

[Whereupon, at 4:20 p.m., Tuesday, April 21, the subcommittee was recessed, to reconvene at a time subject to the call of the Chair.]