

MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2017

THURSDAY, MARCH 10, 2016

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

The subcommittee met at 11:05 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Mark Kirk (chairman) presiding.

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

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. ROBERT A. MCDONALD, SECRETARY

ACCOMPANIED BY:

**HON. DAVID J. SHULKIN, M.D., UNDER SECRETARY FOR HEALTH,
VETERANS HEALTH ADMINISTRATION**

**DANNY G.I. PUMMILL, ACTING UNDER SECRETARY FOR BENEFITS,
VETERANS BENEFITS ADMINISTRATION**

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. The subcommittee will come to order. Good morning. This is the subcommittee's second hearing on the fiscal year 2017 and fiscal year 2018 advance budget request.

The President has requested over \$78 billion in discretionary funding for the Department of Veterans Affairs (VA), an increase of 4.9 percent. This year, there was a request for \$104 billion in advance mandatory benefits funding.

This subcommittee of this Congress has given you everything you wanted, and more. The answer to every VA problem is not "give us more money, give us more flexibility." We need to fix the VA's corrupt culture and all too often poor performance.

We also need to talk about accountability and veterans first and not bureaucrats.

Mr. Secretary, I understand that you will be visiting Illinois next week while in Chicago. I hope you will notice the difference in the culture at a facility that combines the military's healthcare standards with veterans' care.

I want to recognize my friend, the Senator from the Big Sandy metroplex in Montana, Mr. Tester.

STATEMENT OF SENATOR JON TESTER

Senator TESTER. Thank you, Chairman Kirk. Thank you for holding this hearing on the VA's budget.

Secretary McDonald, it is great to have you here today, with your team. Thank you for your service to the veterans of this country.

Last week, we heard testimony from Dr. Shulkin and Mr. Pummill about VA and the Veterans Benefits Administration's (VBA) budget request. I look forward to continuing that discussion today.

As you know, one of my top concerns continues to be the long wait times for veterans trying to get the healthcare through the Choice program. You and I, Mr. Secretary, have had numerous discussions about the failures of the Choice program in my home State. Some of the fault lies with the VA, some lies with Congress. As I said last week, a lot of lies with the third-party administrator in Montana. What they have done and what they are doing is completely unacceptable.

I know time is tight today, so I am not going to rehash the litany of complaints that I receive on a daily basis from frustrated veterans. I know these issues are not isolated to Montana. They are in other States, including Senator Collins' State of Maine.

I do not have to tell you the frustrations are growing up here. I know you hear them. I know you share them. The bottom line is the Choice program is broken. We need to fix it, and we need to fix it as soon as possible.

That is why I introduced legislation last week that will fix the issues we are having with Choice. Moving forward, it will put in place a less complex and confusing framework for Care in the Community. That will reduce administrative burdens both for community providers and for the VA, and connect veterans to the care they need in a more timely manner, and more streamlined.

Earlier this week, I met with Chairman Isakson, who is chairman of the Senate Veterans' Affairs Committee on this issue. We share the same goals and we share the same concerns. We are now committed to finding a bipartisan solution to address these problems in a comprehensive manner.

Mr. Secretary, I hope we can enlist your effort in that regard. When all is said and done, we have to get it right. Our veterans deserve nothing less.

With regard to your budget request, as I see it, there are some very good things in it, but there are also some things that need further explanation.

Failure to account for sustained costs of doctors and nurses that we have hired with Choice Act funds is one. The overall reduction in capital budget is yet another.

I look forward to addressing these issues and other issues with you today and in the weeks ahead. Again, I want to thank you for your service. Thank you for being here today.

Thank you, Mr. Chairman.

Senator KIRK. Thank you.

I want to welcome our witnesses. Secretary McDonald is a graduate of West Point and the Secretary of Veterans Affairs. He is accompanied by Dr. David Shulkin, the Under Secretary for Health,

and Mr. Danny Pummill, the Acting Under Secretary for Benefits. I welcome you both back to the subcommittee. Welcome, gentlemen.

SUMMARY STATEMENT OF HON. ROBERT A. McDONALD

Secretary McDONALD. Chairman Kirk, Ranking Member Tester, members of the subcommittee, thanks for the opportunity to present the President's 2017 budget and 2018 advance appropriations request for the Department of Veterans Affairs. I have submitted a written statement for the record.

The President's 2017 budget proposal is another tangible sign of his devotion to veterans and their families. It proposes \$182.3 billion for the department in fiscal year 2017, which includes \$78.7 billion in discretionary funding, a 4.9-percent increase above the 2016 enacted level, largely for healthcare. It includes \$65 billion for medical care, a 6.3-percent increase of \$3.9 billion over 2016's enacted level. It includes \$12.2 billion for Care in the Community and the new Medical Community Care budget account to increase transparency on VA spending for non-VA care, as required in the VA budget and Choice Improvement Act. It provides \$66.4 billion in advance appropriations for VA medical care programs in 2018, a 2.1 percent increase above the 2017 request. It provides \$7.8 billion for mental health. It funds veteran contact centers, and it funds veteran crisis line modernization.

This proposal provides \$1.5 billion for effective hepatitis C treatments for at least 35,000 veterans, but perhaps significantly more depending upon the pricing of the drugs.

It provides \$1.2 billion for telehealth access, \$725 million for veteran caregivers, and \$515 million for health programs for women veterans.

The proposal includes \$103.6 billion in mandatory funding for veteran benefit programs in 2017 and \$103.9 billion in advance appropriations for our three major mandatory Veteran Benefits Accounts.

It requests \$2.8 billion for the Veterans Benefits Administration, including support for an additional 300 staff to reduce the non-rating claim inventory and provide veterans with more timely decisions on nonrating claims.

And it includes \$156.1 million for the Board of Veterans Appeals, an increase of 42 percent over the 2016 level. This is a down payment on a long-term, sustainable plan to eliminate the appeals backlog.

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

It provides \$2.6 million for the MyVA program office to help integrate MyVA initiatives across the enterprise, and \$72.6 million for the Veterans Experience Office, so we can continue establishing high customer service standards.

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

Over 3 decades in the private sector, I learned first-hand what it takes to be a high-performance organization, and that goal is within our reach. We already have a clear purpose and strong values and strong strategies. We have a growing team of talented business and healthcare professionals making innovative changes. Ten of our top 16 executives are new since I became Secretary, and we are building responsive systems and processes shaped by design to meet veterans' needs.

For veterans, that means they have 24/7 access to VA systems and know where to get answers. Veterans calling or visiting primary care facilities at a medical center have clinical needs addressed the same day. Veterans engaged in mental healthcare needing urgent attention speak to a provider the same day. And veterans calling for a new mental health appointment receive suicide risk assessments and immediate care, if needed.

For employees serving veterans, it means training on advanced business techniques that drive responsive and innovative change. It means clear performance expectations, continuous feedback, and performance management systems that encourage continuous improvement and excellence.

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

We are advancing along all of these lines and many others. Growing a high-performing culture is what our Leaders Developing Leaders (LDL) program is all about. Leaders Developing Leaders is a continuous, enterprise-wide process to instill lasting change.

We launched LDL last November with 450 senior field leaders, and we have trained more than 5,000 leaders so far. We met again last week to build on growing momentum and share best practices that we will leverage across the VA. By year's end, we will have over 12,000 senior leaders empowering more and more teams to dramatically improve care and service delivery to veterans.

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

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

Our pharmacy benefits management program avoided \$4.2 billion in unnecessary drug expenditures last year. We have saved over \$500 million in travel spending since 2013, exceeding goals of the President's campaign to cut waste.

We have reduced employee award spending \$150 million, and Senior Executive Service (SES) bonuses 64 percent between 2011 and 2015 by rigorously linking awards to performance.

Since 2011, we have saved \$16.6 million using more efficient training and meeting methods. We have already saved \$10 million a year under the MyVA five district structure that we announced in January 2015.

We saved approximately \$5.5 million from 2011 to 2015 by strengthening controls over permanent change of station moves. And we will save millions each year in paper storage since we implemented electronic claims processing.

So we are committed to doing everything we can for veterans with everything we are given.

But more than 100 legislative proposals for meaningful change require congressional action. Over 40 are new this year, some absolutely critical to maintaining our ability to purchase non-VA care.

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

Above all, this needs to be done in this Congress. I have consistently identified it as a top legislative priority. We provided detailed legislation addressing this challenge over 9 months ago. Members of this Committee and others in Congress have introduced legislation to address these issues. Now we look forward to working with you to ensure we get this right.

The budget proposes a simplified, streamlined, and fair appeals process, so that in 5 years, veterans could have appeals resolved within 1 year of filing. The statutory appeals process is archaic and unresponsive, not serving veterans well. Last year, the board was still adjudicating an appeal that originated 25 years ago and had been decided more than 27 times.

Legislating a simplified process can save over \$139 million annually beginning in 2022.

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

Likewise, we are looking at how we can treat our career executives more like their private sector counterparts, and we are working with our stakeholders to shape a plan that best serves veterans.

The budget proposes appropriations language for general transfer authority that allows me some measured spending flexibility to respond to veterans' emerging needs.

We need congressional authorization for 18 leases submitted in the VA's 2015 fiscal year and 2016 budget request. We need authorization for eight major construction projects included in VA's 2016 fiscal year request. And we need support for the six additional replacement major medical facility leases in the 2017 budget. And passing special legislation for VA's West Los Angeles campus will get positive results for veterans there who are most in need.

This Congress with today's VA leadership team can make these changes and more. And it is all for veterans. Then we can look back on this year as the year that we turned the corner.

I appreciate this opportunity and the support you have shown veterans, the department, and the MyVA transformation, and I look forward to answering your questions.

Thank you, Mr. Chairman.

[The statement follows:]

PREPARED STATEMENT OF HON. ROBERT A. McDONALD

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

A VISION FOR THE FUTURE

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

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

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

Listening to others' perspectives and insights has been, and remains, instrumental in shaping our transformation. We have taken advantage of an unprecedented level of outreach to the field and our stakeholders. In my first months as Secretary, I assessed VA and recognized that we would need to change fundamental aspects of every part of VA in order to rise to excellence. I shared my assessment's results with President Obama and received his guidance. I discussed my findings with you and other Members of Congress—privately and during hearings. And I consulted with literally thousands of veterans, VA clinicians, VA employees, and Veteran Service Organizations (VSOs) and other stakeholders in dozens of meetings.

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

Progress

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

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

in the country; a former entrepreneur and CEO of multiple technology companies; and a retired Disney executive who spent 2010–2011 at Walter Reed National Military Medical Center enhancing the patient experience.

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

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

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

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



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

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

dent who was a Rhodes Scholar from the Air Force Academy who currently serves as a reserve Air Force Lieutenant Colonel, and advocates for both the traditional VSOs and post-9/11 veterans' organizations.

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

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



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

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

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

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

Collaborating with partners

WE HAVE BEEN CONSULTING WITH OUR KEY STAKEHOLDERS ON HOW TO IMPLEMENT CHANGE

U.S. Department of Veterans Affairs

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

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

We continue to listen, learn, and grow.

In 2015, we were guided by and made notable progress toward reaching our three Agency Priority Goals (APGs)—(1) Improve Veteran Access to VA Benefits and Services, (2) End Veteran Homelessness, and (3) Eliminate the Disability Claims Back-

log. These accomplishments toward achieving our APGs demonstrate VA's commitment to using our resources effectively to improve care and benefits for veterans.

Access

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

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

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

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

In the first Access Stand Down, VHA reviewed nearly 55,800 of the more than 56,000 urgent consults that remained open more than 30 days (as of November 6, 2015), a herculean effort. Of those 55,800 urgent open consults reviewed, 82 percent (45,849) were scheduled or closed by the end of that first Stand Down.

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

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

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

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

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

Care in the Community

In 2015, VA obligated \$10.5 billion for Veterans Care in the Community, including resources provided through the Veterans Choice Act—an increase of \$2.3 billion (28 percent) over the 2014 level—which resulted in nearly 2.4 million authorizations for veterans to receive Care in the Community from December 3, 2014 through December 2, 2015. Programmatically, this included care in the community for veterans'

dialysis, state home programs, community nursing care, veterans home programs, emergency care, private medical facilities care, and care delivered at Indian health clinics. It also includes care under VA's CHAMPVA program for certain dependents entitled to that care.

Homelessness

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

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

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

Disability Claims Backlog

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



In fiscal year 2015, VA decided a record-breaking 1.4 million disability compensation and pension (rating) claims for veterans and their survivors—the highest in VA

history for a single year. As of December 31, 2015, VA had driven down the disability claims backlog to 75,480, from a peak of over 611,000 in March 2013.

2016–2017 VA’s Agency Priority Goals

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

FISCAL YEAR 2017 BUDGET REQUEST

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

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

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

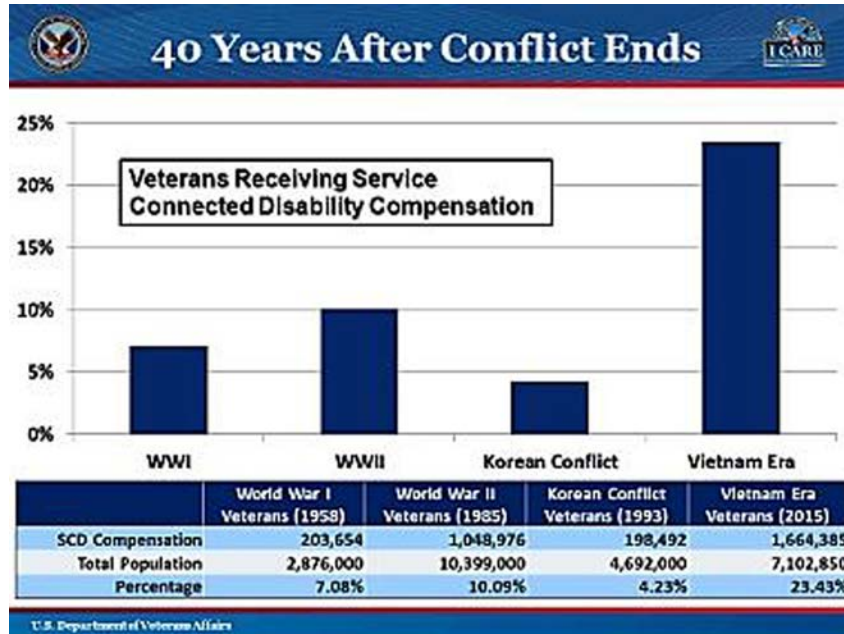
RIISING DEMAND FOR VA CARE AND BENEFITS

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

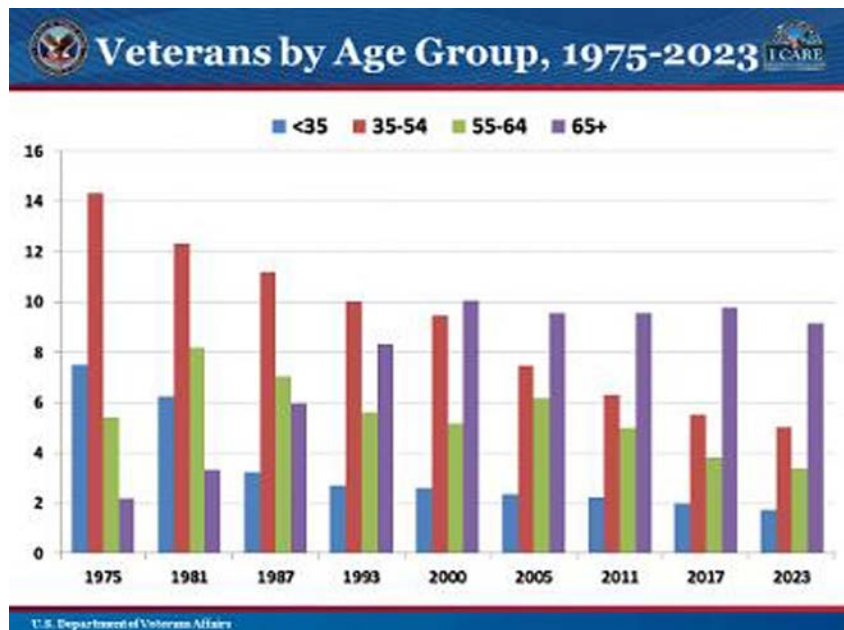
In 2014, when the Phoenix access difficulties came to light, VA had 300,000 appointments that could not be completed within 30 days of the date the veteran needed or wanted to be seen. To meet that demand, VA rallied to add capacity to complete 300,000 more appointments each month, or about 3.5 million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

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

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



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



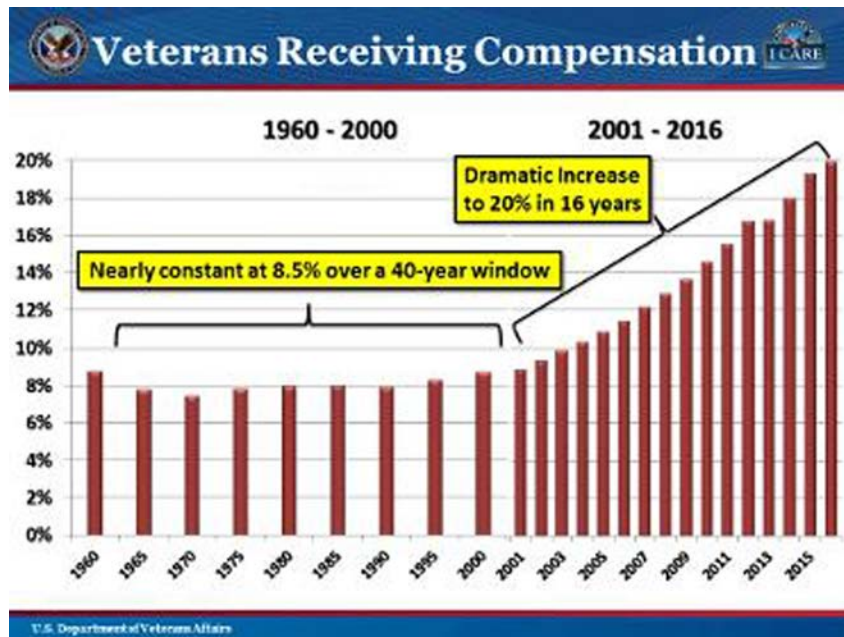
Compared to fiscal year 2009, the number of patients is projected to increase by 22 percent by fiscal year 2017. And, as veterans see the results of VA's trans-

formation, we are confident that the number of veterans utilizing VA services will continue to rise. Currently, 11 million of the 22 million veterans in this country are registered, enrolled, or use at least one VA benefit or service.

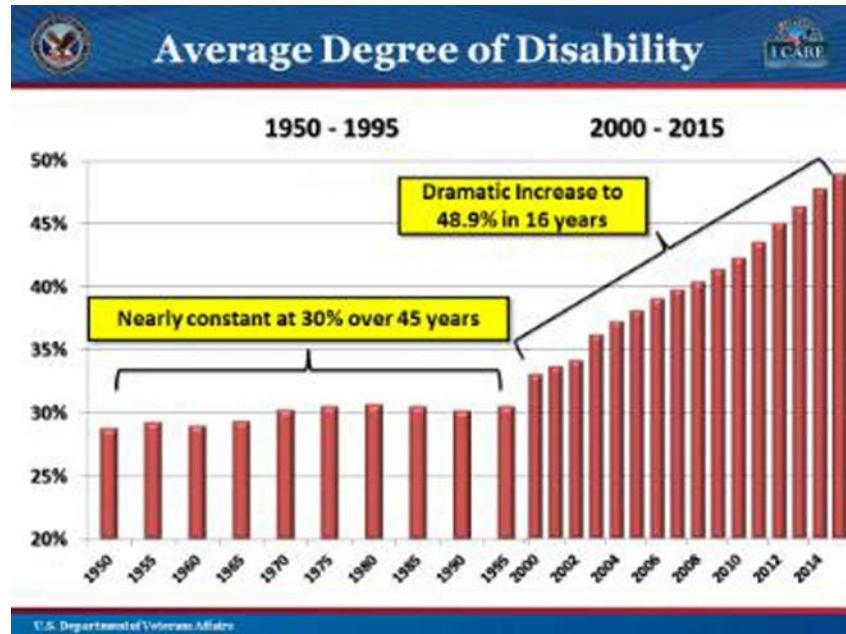
Veterans' healthcare and benefit requirements continue to increase decades after conflicts end, and this fact is a fundamental, long-term challenge for VA. Forty years after the Vietnam war ended, the number of Vietnam era veterans receiving disability compensation has not yet peaked. VA anticipates a similar trend for Gulf war era veterans, only 26 percent of whom have been awarded disability compensation.

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

While the percent of the veteran population receiving compensation was nearly constant at 8.5 percent for more than 40 years, over the past 15 years there has been a striking increase to 20 percent. The total number of service-connected disabilities for veterans receiving compensation grew from 11.8 million in 2009 to 19.7 million in 2015, an increase of more than 67 percent in just 6 years. This dramatic growth, combined with estimates based on historic trends, predicts an even greater increase in claims for more benefits as veterans age and disabilities become more acute.



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



As VA continues to improve access and quality of care, more veterans will come to VA for more of their care. Veterans today often choose VA for care either because of personal preference or because of VA's economic edge. Some 78 percent of enrolled veterans at VA have other choices like Medicare, Medicaid, Tricare, or private insurance. Out-of-pocket cost for veterans at VA is often lower, and cost considerations are a key factor in veterans' demand for VA healthcare. In 2014, veteran enrollees received only 34 percent of their total healthcare through VA, accounting for about \$53 billion in 2014 costs. Just a 1 percent increase in veteran reliance on VA healthcare will increase costs by \$1.4 billion.

PRODUCTIVITY IMPROVEMENTS AND STEWARDSHIP

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

BENEFITS CLAIMS PROCESS

PAPER CLAIMS DIGITIZED THROUGH THE VETERANS CLAIMS INTAKE PROGRAM

Since 2012, VA has scanned paper claim material into the Veterans Benefits Management System (VBMS).



To boost efficiency and employee productivity, VA is quickly moving to paperless claims processing from its historically manual, paper-intensive process. Modernizing to an electronic claims processing system has helped VBA increase claim productivity per claims processor by 25 percent since 2011 and medical issue productivity by 82 percent per claims processor since 2009. This significant productivity increase helped mitigate the effects of the 131 percent increase in workload between 2009 and 2015, when the number of medical issues rose from 2.7 million to 6.4 million. VA's shift to electronic claims processing has meant converting paper files to eFolders. Between 2012 and 2015, the Veterans Claims Intake Program (VCIP) scanned nearly 6 million claims files into veterans' eFolders in the Veterans Benefits Management System (VBMS). VBA has removed more than 7,000 tons of claims-related papers formerly undermining efficiency, hampering productivity, and cluttering workspace.

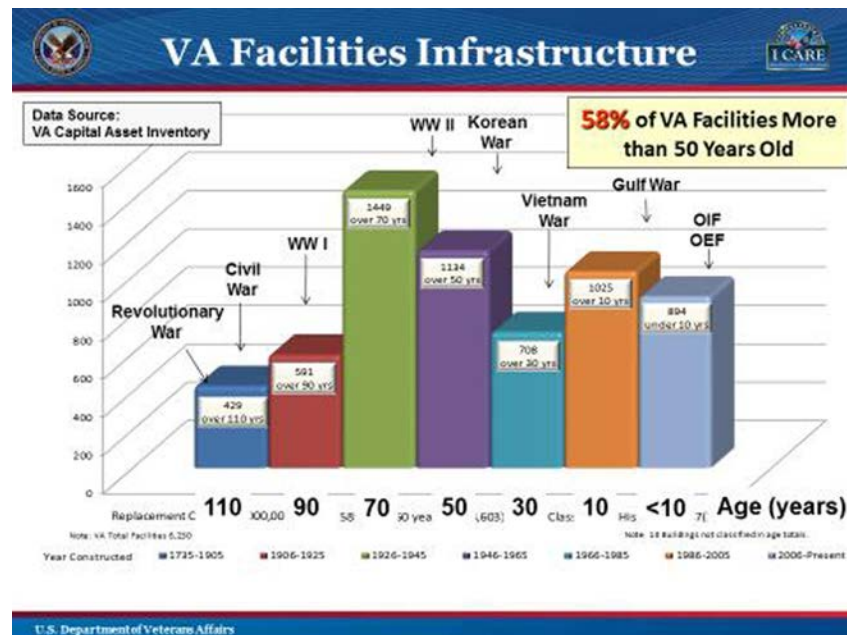
In fiscal year 2015, VBA deployed its innovative Centralized Mail Initiative to 56 regional offices (ROs) and one pension management center (PMC). Centralized Mail reroutes inbound compensation and pension claims-related mail directly to Claims and Evidence Intake Centers at document conversion services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

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

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

CLOSING UNSUSTAINABLE FACILITIES

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



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



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

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

ENSURING VETERANS ACCESS TO CARE

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

The 2017 budget requests \$65 billion for medical care, an increase of \$3.9 billion (6.3 percent) over the 2016 enacted level. The increase in 2017 is driven by veterans' demand for VA healthcare as a result of demographic factors, economic assumptions, investments in access, and high priority investments for caregivers, new Hepatitis C treatments, and support for Veterans Care in the Community. The 2017 request supports programs to end and prevent veteran homelessness, invests in strategic initiatives to improve the quality and accessibility of VA healthcare programs, continues implementation of the Caregivers and Veterans Omnibus Health Services Act, and provides for activation requirements for new or replacement medical facilities. The 2017 appropriations request includes an additional \$1.7 billion above the enacted 2017 AA for veterans medical care. The request assumes approximately \$3.6 billion annually in medical collections in 2017 and 2018. For the 2018 Advance Appropriations for medical care, the current request is \$66.4 billion.

Hepatitis C Treatment

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

VA is the largest single provider of care in the Nation for chronic HCV, and over the next 5 years, VA will strive to provide treatment to all veterans with HCV who are treatment candidates. For fiscal year 2017, VA is requesting \$1.5 billion for the cost of Hepatitis C drugs and clinical resources. With a budget of \$1.5 billion in fiscal year 2017, VA expects to treat at least 35,000 patients with HCV; the actual number of patients treated will depend on the cost to VA of Hepatitis C drugs. At the beginning of fiscal year 2016, almost 120,000 veterans in VA care were awaiting HCV treatment, of whom approximately 30,000 have advanced liver disease.

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

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

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

Care in the Community

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

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

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

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

- In fiscal year 2015, enrollees' reliance on VA healthcare increased by 0.7 percent overall. Reliance for the 40-mile group increased by 2.8 percentage points from 32.5 percent to 35.3 percent.
- The increase in reliance was mostly driven by growth in Care in the Community. Cost sharing levels in VA are lower than what is typically available else-

where, which provides an incentive for enrollees to use VA-paid Care in the Community.

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

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

Caregiver Support Program

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

The 2017 budget requests \$725 million for the National Caregivers Support Program to support nearly 36,600 caregivers, up from about 30,600 in fiscal year 2016. Funding requirements for caregivers are driven by an increase in the eligible veteran population, with caregiver enrollment increasing by an average of about 500 each month.

ENDING VETERAN HOMELESSNESS

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

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

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

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

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

BENEFITS PROGRAMS

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

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

- Disability compensation and pension benefits for 5.3 million veterans and survivors, totaling \$86 billion;
- Vocational rehabilitation and employment benefits to nearly 141 thousand disabled veterans, totaling \$1.4 billion;
- Education benefits totaling \$14 billion to more than one million veterans and family members;

- Guaranty of more than 429,000 new home loans; and
- Life insurance coverage to 1.0 million veterans, 2.2 million servicemembers, and 2.8 million family members.

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

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

—*Non-rating claims.* VA completed nearly 37 percent more non-rating work in 2015 than 2013—and 15 percent more than 2014. The 2017 budget requests \$29.1 million for an additional 300 non-rating claims processors to reduce the non-rating claims inventory and provide veterans with more timely decisions on non-rating claims.

—*Appeals.* Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA continues to receive and complete record-breaking numbers of disability rating claims, the volume of appeals correspondingly increases. As of December 31, 2015, there were more than 440,000 benefits-related appeals pending in the Department at various stages in the multi-step appeals process, which divides responsibility between VBA and the Board of Veterans' Appeals (Board)—355,803 of those benefits-related appeals are in VBA's jurisdiction and 85,682 are within the Board's jurisdiction.

Under current law, VA appeals framework is complex, ineffective, and opaque, and veterans wait on average 5 years for final resolution of an appeal. The 2017 budget supports the development of a Simplified Appeals Process to provide veterans with a simple, fair, and streamlined appeals procedure in which they would receive a final appeals decision within 365 days from filing of an appeal by fiscal year 2021. The 2017 budget provides funding to support over 900 FTE for the Board and proposes a legislative change that will improve an outdated and inefficient process which will benefit all veterans through expediency and accuracy. We look forward to working with Congress, veterans, and other stakeholders to implement improvements.

—*Fiduciary program.* The fiduciary program served 29 percent more beneficiaries in 2015 than it served in 2014. Program growth is primarily due to an increase in the total number of individuals receiving VA benefits and an aging population of beneficiaries. Additionally, in 2015 the fiduciary program changed the way it captures beneficiary population data and now reports all beneficiaries served during the course of the fiscal year. In 2015, fiduciary personnel conducted more than 84,000 field examinations, and VBA anticipates field examination requirements will exceed 97,000 in 2017.

—*Housing program.* The 2017 budget includes \$34 million for the VA Loan Electronic Reporting Interface (VALERI) to manage the 2.4 million VA-guaranteed loans for veterans and their families. VALERI connects VA with more than 320,000 veteran borrowers and more than 225,000 mortgage servicer contacts. VA uses the VALERI tool to manage and monitor efforts taken by private-sector loan servicers and VA staff in providing timely and appropriate loss mitigation assistance to defaulted borrowers. Without these resources, approximately 90,000 veterans and their families would be in jeopardy of losing their homes each year, potentially costing the Government an additional \$2.8 billion per year. VALERI also supports payment of guaranty and acquisition claims.

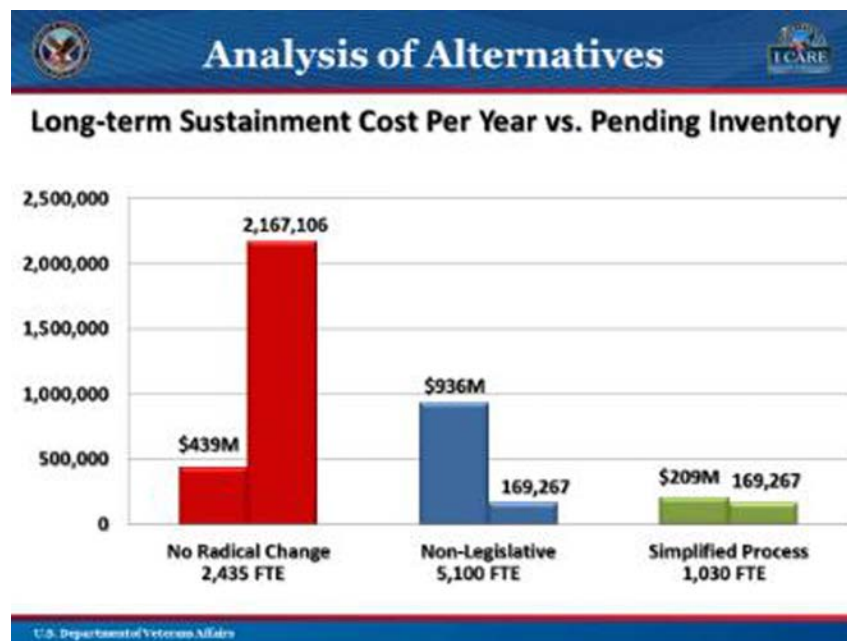
The budget requests the following advance appropriations amounts for 2018: \$90.1 billion for compensation and pensions, \$13.7 billion for readjustment benefits, and \$107.9 billion for insurance and indemnities. VA will continue to closely monitor workload and monthly expenditures in these programs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

THE SIMPLIFIED APPEALS INITIATIVE

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

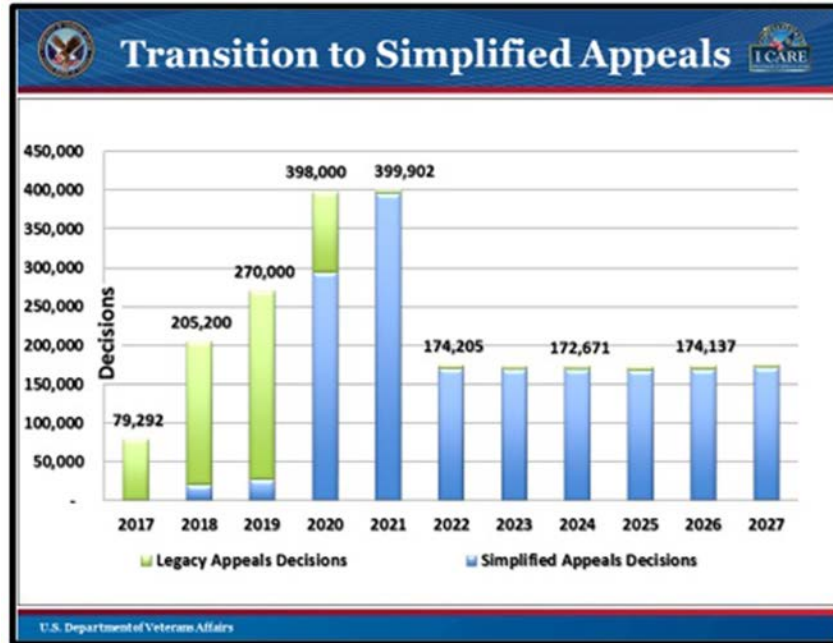
Under current law, the VA appeals framework is complex, ineffective, confusing, and understandably frustrating for veterans who wait much too long for final resolution of their appeal. The current appeals system has no defined endpoint, and multiple steps are set in statute. The system requires continuous evidence gathering and multiple re-adjudications of the very same or similar matter. A veteran, survivor, or other appellant can submit new evidence or make new arguments at any time, while VA's duty to assist requires continuous development and re-adjudication. Simply put, the VA appeals process is unlike other standard appeals processes across Federal and judicial systems.

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



The 2017 budget proposes a Simplified Appeals Process—legislation and resources (i.e., people, process, and technology) that would provide veterans with a simple, fair, and streamlined appeals process in which they would receive a final decision on their appeal within 1 year from filing the appeal by fiscal year 2021.

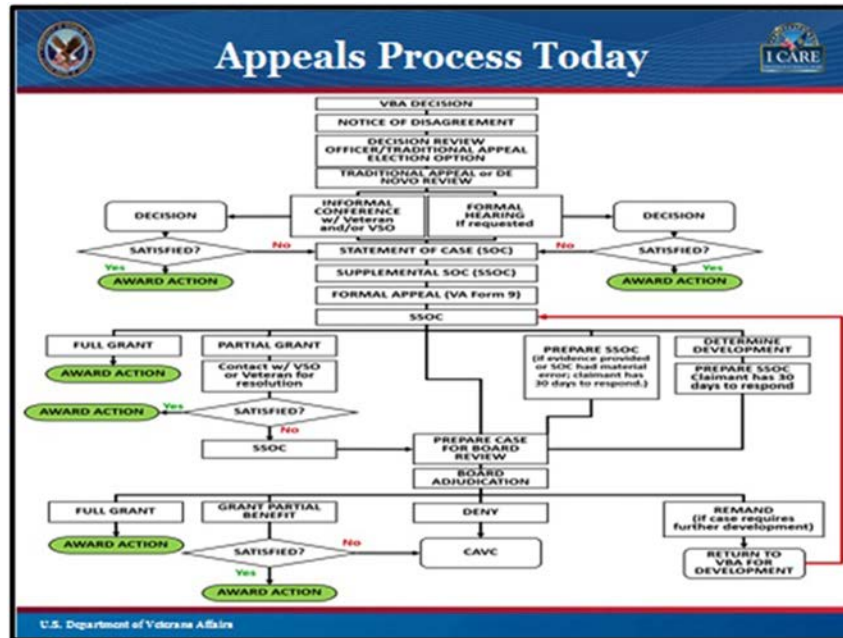
The 2017 budget requests \$156.1 million and 922 FTE for the Board, an increase of \$46.2 million and 242 FTE above the fiscal year 2016 enacted level. This is a down-payment on a long-term, sustainable plan to provide the best services to veterans. This policy option also represents the best value to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



Simplified Appeals Process: Ramp Up and Long-Term Sustainment

Without legislative change or significant increases in staffing, VA will face a soaring appeals inventory, and veterans will wait even longer for a decision on their appeal. If Congress fails to enact VA's proposed legislation to simplify the appeals process, Congress would need to provide resources for VA to sustain more than double its appeals FTE, with approximately 5,100 appeals FTE onboard. The prospect of such a dramatic increase, while ignoring the need for structural reform, is not a good result for veterans or taxpayers.

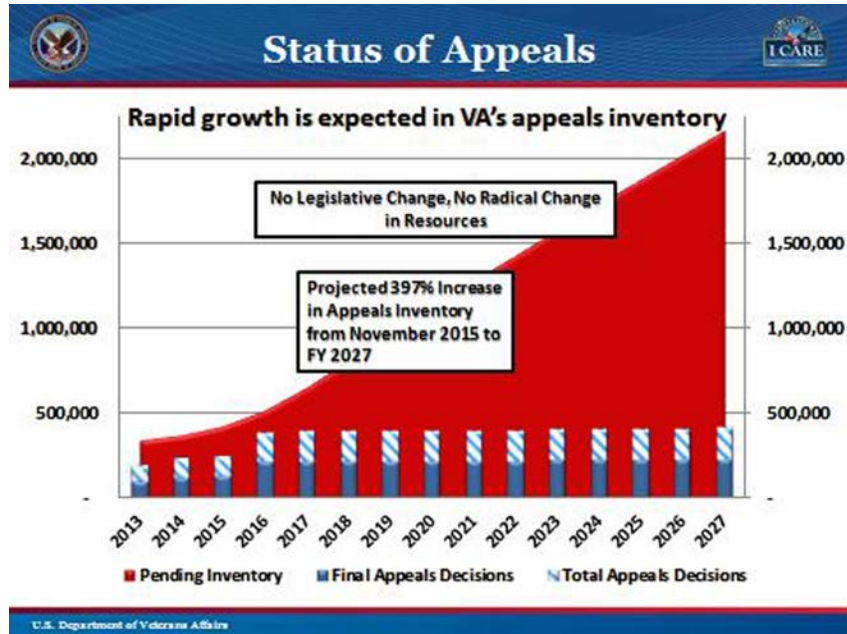
While the Simplified Appeals proposal would require FTE increases for the first several years to resolve the more than 440,000 currently pending appeals, by 2022, VA would be able to reduce appeals FTE to a sustainment level of roughly 1,030 FTE (including 980 FTE at the Board and 50 at VBA), a level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



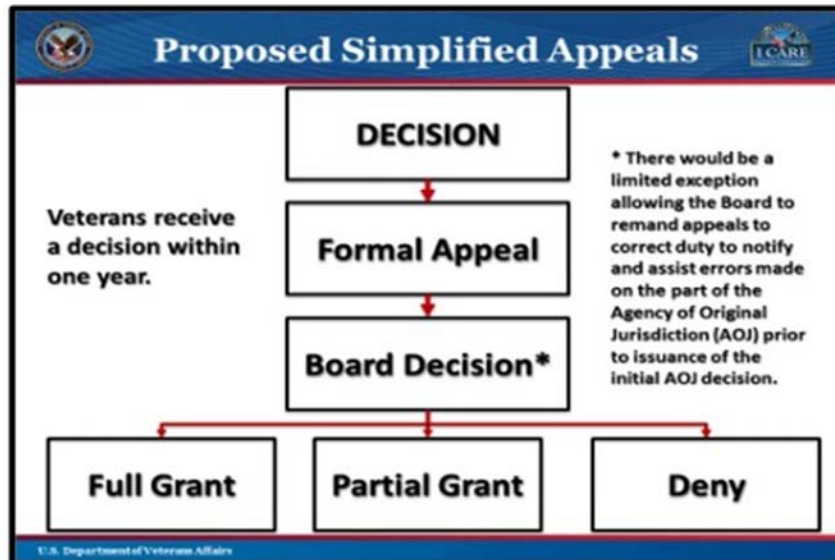
**In today's Convolted Appeals Process, Veterans Wait 5 Years
for a Decision**

In 2015, the Board was still adjudicating an appeal that originated 25 years ago, even though the appeal had previously been decided by VA more than 27 times. Under the Simplified Appeals Process, most veterans would receive a final appeals decision within 1 year of filing an appeal. Additionally, rather than trying to navigate a multi-step process that is too complex and too difficult to understand, veterans would be afforded a transparent, single-step appeal process with only one entity responsible for processing the appeal. Essentially, under a simplified appeals process, as soon as a veteran files an appeal, the case would go straight to the Board where a Judge would review the same record considered by the initial decision-maker and issue a final decision within 1 year; informing the veteran whether that initial decision was substantially correct, contained an error that must be corrected, or was simply wrong. If a veteran disagrees with any or all of the final appeals decision, the veteran always has the option of filing a new claim for the same benefit once the appeal is resolved, or may pursue an appeal to the Court of Appeals for Veterans Claims.

Rapid growth in the appeals workload exacerbates this challenge. As VBA has produced record-setting claims-decision output over the past 5 years, appeals volume has grown commensurately. Between December 2012 and November 2015, the number of pending appeals rose by 34 percent. Under current law with no radical change in resources, the number of pending appeals is projected to soar by 397 percent—from 437,000 to 2.17 million (chart, Status of Appeals)—between November 2015 and fiscal year 2027.



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



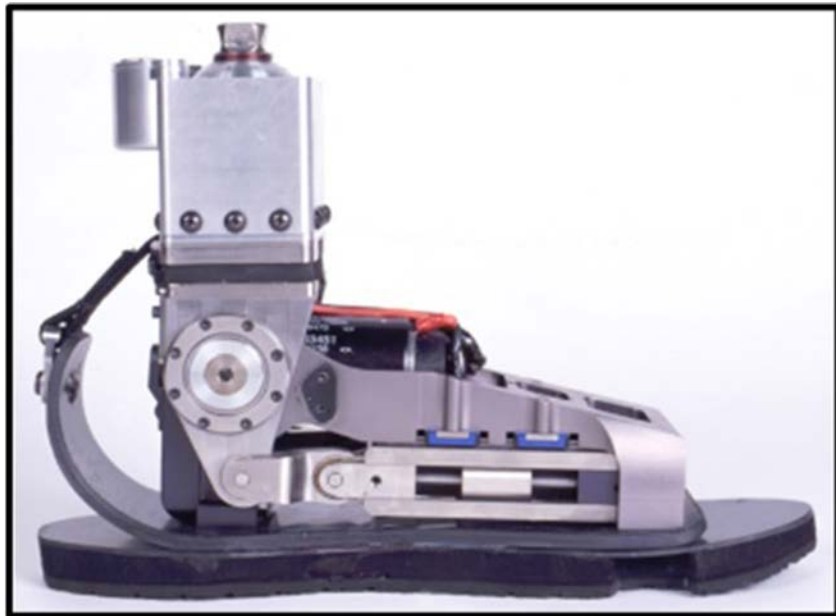
**VA's Proposed Simplified Appeals Process:
Veterans Receive an Appeal Decision Within One Year**

MEDICAL AND PROSTHETIC RESEARCH

The 2017 budget continues VA's program of groundbreaking, high standard research focused on advancing the healthcare needs of all veterans. The 2017 budget requests \$663 million for Medical Research and supports the President's Precision Medicine Initiative (PMI) to drive personalized medical treatment and the evolving science of Genomic Medicine—how genes affect health. In addition to the direct appropriation, Medical Research will be supported through \$1.3 billion from VA's Medical Care program and other Federal and non-Federal research grants. Total funding for Medical and Prosthetic Research will be more than \$2.0 billion in 2017.

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

For more than 90 years, VA research has produced cutting-edge medical and prosthetic breakthroughs that improve the lives of veterans and others. The list of accomplishments includes therapies for tuberculosis following World War II, the implantable cardiac pacemaker, computerized axial tomography (CAT) scans, functional electrical stimulation systems that allow patients to move paralyzed limbs, the nicotine patch, the first successful liver transplants, the first powered ankle-foot prosthesis, and a vaccine for shingles. VA researchers also found that one aspirin a day reduces by half the rate of death and nonfatal heart attacks in patients with unstable angina. More recently, VA investigators tested an insulin nasal spray that shows great promise in warding off Alzheimer's disease and found that prazosin (a well-tested generic drug used to treat high blood pressure and prostate problems) can help improve sleep and lessen nightmares for those with post-traumatic stress disorder.



The First Powered Ankle-Foot Prosthesis

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

most effective medication for them. This initiative will focus on up to 21,500 veterans with PTSD, depression, pain, and/or substance abuse.



VA's Million Veteran Program Recruitment

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

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

VA's research and development program improves the lives of veterans and all Americans through healthcare discovery and innovation.

OTHER PRIORITIES

Information Technology

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

(FITARA) compliant processes led by the Chief Information Officer (CIO), in concert with the Chief Financial Officer and Chief Acquisition Officer.

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

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

National Cemetery Administration

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

VA INFRASTRUCTURE

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

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

Leasing provides flexibility and enables VA to more quickly adapt to changes in medical technology, workload, new programs, and demographics. VA is also looking to Congress for authorization of 18 leases submitted in VA's fiscal year 2015 and 2016 budget requests. The pending major medical facility lease projects will replace, expand, or create new outpatient clinics and research facilities and are critical for providing access for veterans and enhancing our research capabilities nationwide. The 2017 budget includes a request to authorize six additional replacement major medical facility leases under VA's authority in 38 U.S.C. §§ 8103 and 8104 and with the anticipated delegation of leasing authority from the General Services Administration. The Department is awaiting authorization of its request to expand the definition of "Medical Facilities" in VA's authorizing statutes to allow VA to more easily partner with other Federal agencies. Another proposal that deserves attention is authorization of enhanced use lease (EUL) authority to encompass broader possibilities for mixed-use projects. This change would give VA more opportunities to engage the private sector, local governments, and community partners by allowing VA to use underutilized property that would benefit veterans and VA's mission and operations.

Major Construction

The 2017 budget requests \$528.1 million for Major Construction. The request includes funds to address seismic problems in facilities in Long Beach, California, and Reno, Nevada. These projects will correct critical safety and seismic deficiencies that

pose a risk to veterans, VA staff, and the public. Consistent with Public Law 114–58, the Department must identify a non-VA entity to execute these two projects, as they are more than \$100 million. We have identified the U.S. Army Corps of Engineers as our construction agent to execute these projects.



San Fernando Medical Center collapse, 1971

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

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



San Francisco Medical Center



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

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

Minor Construction

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

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

Leasing

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

MYVA TRANSFORMATION

MyVA Transformation

Make Veterans want to be our customer

myVA Objectives

- Improving the **Veteran Experience**
- Improving the **Employee Experience**
- Improving **Internal Support Services**
- Establishing a Culture of **Continuous Improvement**
- Enhancing **Strategic Partnerships**

The Washington Post

VA Now the #1 Federal Agency

U.S. Department of Veterans Affairs

MyVA puts veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider—a framework for modernizing VA's culture, processes, and capabilities to put the needs, expectations, and in-

terests of veterans and their families first. A veteran walking into any VA facility should have a consistent, high-quality experience.

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

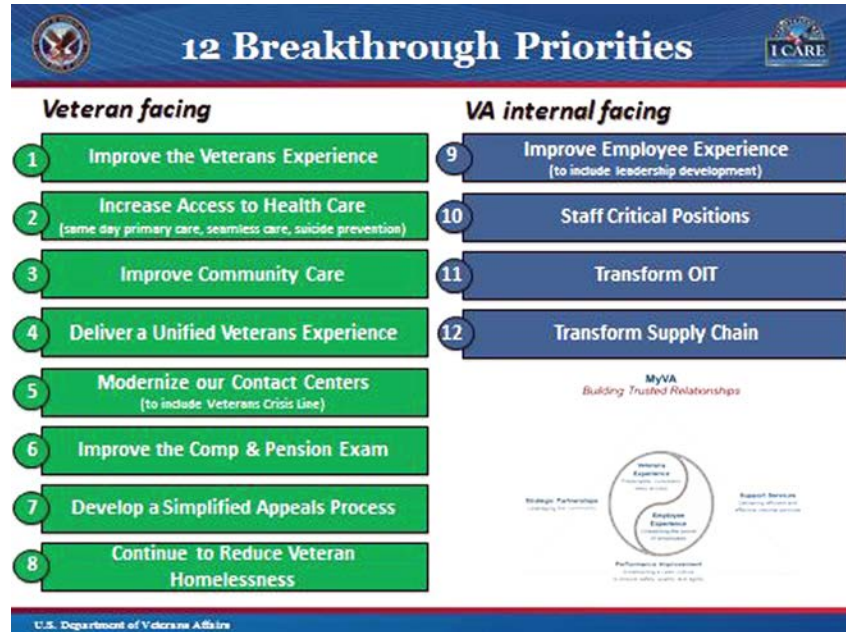
The fiscal year 2017 budget will make investments toward the five critical MyVA objectives:

1. *Improving the veteran experience:* At a bare minimum, every contact between veterans and VA should be predictable, consistent, and easy; however, we are aiming to make each touchpoint exceptional. It begins with receptionists who are pleasant to our veteran clients, but there is also a science to this experience. We are focusing on human-centered design, process mapping, and working with leading design firms to learn and use the technology associated with improving every interaction with clients.
2. *Improving the employee experience—so we can better serve veterans:* VA employees are the face of VA. They provide care, information, and access to earned benefits. They serve with distinction daily. We cannot make things better for veterans without improving the work experience of our dedicated employees. We must train them. We must move from a rules/fear-based culture to a principles/values-based culture. I learned in the private sector that it is absolutely not a coincidence that the very best customer-service organizations are almost always among the best places to work.
3. *Improving internal support services:* We will let employees and leaders focus on assisting veterans, rather than worrying about “back office” issues. We must bring our IT infrastructure into the 21st century. Our scheduling system, where many of our issues with access to care were manifest, dates to 1985. Our Financial Management System is written in COBOL, a language I used in 1973. This is simply unacceptable. It impedes all of our efforts to best serve veterans.
4. *Establishing a culture of continuous improvement:* We will apply Lean strategies and other performance improvement capabilities to help employees examine their processes in new ways and build a culture of continuous improvement.
5. *Enhancing strategic partnerships:* Expanding our partnerships will allow us to extend the reach of services available for veterans and their families. We must work effectively with those who bring capabilities and resources to help veterans.

Breakthrough Priorities for CY 2016

While we have made progress, we are still on the first leg of a multi-year journey. We have narrowed down our near-term focus to 12 “breakthrough priorities.”

Many of these reflect issues which are not new—they have been known problems, in some cases, for years. We have already seen some progress in solving many of them. However, we still have much work to do.



The following are our 12 priorities and the 2016 outcomes to which we aspire. We understand that it will be a challenge to accomplish all of these goals this year, but we have committed ourselves to producing results for veterans and creating irreversible momentum to continue the transformation in future years.

Veteran Facing Goals

1. Improve the Veteran Experience.
 - Breakthrough Outcome for 2016:*
 - Strengthen the trust in VA to fulfill our country's commitment to veterans; currently measured at 47 percent, we want it to be 70 percent by year end.
 - Establish a Department-wide customer experience measurement framework to enable data-driven service improvements.
 - Make the Veterans Experience office fully operational.
 - Expand the network of Community Veteran Engagement Boards to more than 100.
 - Additionally, in order to deliver experiences to veterans that are effective, easy, and in which veterans feel valued, medical centers will ensure that they are fully staffed at the frontline with well-prepared employees who have been selected for their customer service. Functionally, this means new frontline staff will be assessed through a common set of customer service criteria, hired within 30 days of selection, and provided a nationally standardized onboarding and training program.
2. Increase Access to Health Care.
 - Breakthrough Outcome for 2016:*
 - When veterans call or visit primary care facilities at a VA Medical Center, their clinical needs will be addressed the same day.
 - When veterans call for a new mental health appointment, they receive a suicide risk assessment and immediate care if needed. Veterans already engaged in mental healthcare identifying a need for urgent attention will speak with a provider the same day.
 - Utilizing existing VistA technology, veterans will be able to conveniently get medically necessary care, referrals, and information from any VA Medical Center, in addition to the facility where they typically receive their care.
3. Improve Community Care.

- Breakthrough Outcome for 2016:* Improve the veterans' experience with Care in the Community. Following enactment of our requested legislation, by the end of the year:
 - VA will begin to consolidate and streamline its non-Department Provider Network and improve relationships with community providers and core partners.
 - Veterans will be able to see a community provider within 30 days of their referral.
 - Non-Department claims will be processed and paid within 30 days, 85 percent of the time.
 - Healthcare claims backlog will be reduced to less than 10 percent of total inventory.
 - Referral and authorization time will be reduced.
 - 4. Deliver a Unified Veteran Experience.
 - Breakthrough Outcome for 2016:*
 - Vets.gov will be able to provide veterans, their families, and caregivers with a single, easy-to use, and high-performing digital platform to access the VA benefits and services they have earned.
 - Vets.gov will be data-driven and designed such that the top 100 search terms will be available within one click from search results. The top 100 search terms will all be addressed within one click on the site.
 - All current content, features and forms from the current public-facing VA websites will be redesigned, rewritten in plain language, and migrated to Vets.gov, in priority order based on veteran demand.
 - Additionally, we will have one authoritative source of customer data; eliminating the disparate streams of Administration-specific data that require veterans to replicate inputs.
 - 5. Modernize our Contact Centers (Including Veterans Crisis Line).
 - Breakthrough Outcome for 2016:*
 - Veterans will have a single toll free phone number to access the VA Contact Centers, know where to call to get their questions answered, receive prompt service and accurate answers, and be treated with kindness and respect. VA will do this by establishing the initial conditions necessary for an integrated system of customer contact centers.
 - By the end of this year, every veteran in crisis will have his or her call promptly answered by an experienced responder at the Veterans Crisis Line.
 - 6. Improve the Compensation & Pension (C&P) Exam Process.
 - Breakthrough Outcome for 2016:*
 - Improved veteran satisfaction with the C&P Exam process. We have a baseline satisfaction metric in place and have established a goal for significant improvement.
 - VA will have a national rollout of initiatives to ensure the experience is standardized across the Nation.
 - 7. Develop a Simplified Appeal Process.
 - Breakthrough Outcome for 2016:*
 - Subject to successful legislative action, put in place a simplified appeals process, enabling the Department to resolve 90 percent of appeals within 1 year of filing by 2021.
 - Increase current appeals production to more rapidly reduce the existing appeals inventory.
 - 8. Continue Progress in Reducing Veteran Homelessness.
 - Breakthrough Outcome for 2016:*
 - Continue progress toward an effective end to veteran homelessness by permanently housing or preventing homelessness for an additional 100,000 veterans and their family members.
- VA Internal Facing Goals
- 9. Improve the Employee Experience (Including Leadership Development).
 - Breakthrough Outcome for 2016:*
 - Continue to improve the employee experience by developing engaged leaders at all levels who inspire and empower all employees to deliver a seamless, integrated, and responsive VA customer service experience.
 - More than 12,000 engaged leaders skilled in applying LDL principles, concepts, and tools will work projects and/or initiatives to make VA a more effective and efficient organization.

- Improve VA’s employee experience by incorporating LDL principles into VA’s leadership and supervisor development programs and courses of instruction.
 - VA Senior Executive performance plans will include an element that targets how to improve employee engagement and customer service, and all VA employees will have a customer service standard in their performance plans.
 - All VA supervisors will have a customer service standard in their performance plans.
 - VA will begin moving from paper-based individual development plans to a new electronic version, making it easier for both supervisors and employees.
10. Staff Critical Positions.
- Breakthrough Outcome for 2016:*
 - Achieve significantly improved critical staffing levels that balance access and clinical productivity, with targets of 95 percent of Medical Center Director positions filled with permanent appointments (not acting) and 90 percent of other critical shortages addressed—management as well as clinical.
 - Work to reduce “time to fill” hiring standards by 30 percent.
11. Transformation the Office of Information & Technology (OIT).
- Breakthrough Outcome for 2016:* Achieve the following key milestones on the path to creating a world-class IT organization that improves the support to business partners and veterans.
 - Begin measuring IT projects based on end product delivery, starting with a near-term goal to complete 50 percent of projects on time and on budget.
 - Stand up an account management office.
 - Develop portfolios for all Administrations.
 - Tie all supervisors’ and executives’ performance goals to strategic goals.
 - Close all current cybersecurity weaknesses.
 - Develop a holistic veteran data management strategy.
 - Implement a quality and compliance office.
 - Deploy a transformational vendor management strategy.
 - Ensure implementation of key initiatives to improve access to care.
 - Establish one authoritative source for veteran contact information, military service history, and veteran status.
 - Finalize the Congressionally mandated DOD–VA Interoperability requirements.
12. Transform Supply Chain.
- Breakthrough Outcome for 2016:*
 - Build an enterprise-wide integrated Medical-Surgical supply chain that leverages VA’s scale to drive an increase in responsiveness and a reduction in operating costs. More than \$150 million in cost avoidance will be redirected to priority veteran programs.

We are rigorously managing each of these “breakthrough priorities” by instituting a Department level scorecard, metrics, and tracking system. Each priority has an accountable and responsible official and a cross-functional, cross-Department team in support. Each team meets every other week in person with either the Secretary or Deputy Secretary to discuss progress, identify roadblocks, and problem solve solutions. This is a new VA—more transparent, collaborative, and respectful; less formal and bureaucratic; more execution and outcome-focused; principles based, not rules-based.

LEGISLATIVE PRIORITIES

The Department is grateful for your continuing support of veterans and appreciates your efforts to pass legislation enabling VA to provide veterans with the high-quality care they have earned and deserve. We have identified a number of necessary legislative items that require action by Congress in order to best serve veterans going forward:

1. *Improve Care in the Community:* We need your help, as discussed on many occasions, to help overhaul our Care in the Community programs. VA staff and subject matter experts have communicated regularly with congressional staff to discuss concepts and concerns as we shape the future plan and recommendations. We believe that together we can accomplish legislative changes to streamline Care in the Community programs before the end of this session of Congress.

2. *Flexible Budget Authority*: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to veterans. Currently, there are more than 70 line items in VA's budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to veterans. These include limitations within the same general areas, such as healthcare funds that cannot be spent on healthcare needs. These restrictions limit VA's ability to deliver veteran care and benefits based on demand, rather than specific funding lines. The 2017 budget proposes appropriations language to provide VA with new authority to transfer up to 2 percent of the discretionary appropriations for fiscal year 2017 between any of VA's discretionary appropriations accounts, excluding Medical Care. This new authority would give VA greater ability to address emerging needs and overcome artificial funding restrictions on providing veterans' care and benefits.
3. *Support for the Purchased Health Care Streamlining and Modernization Act*: This legislation would clarify VA's ability to contract with providers in the community on an individual basis, outside of Federal Acquisition Regulations (FAR), without forcing providers to meet excessive compliance burdens, while maintaining essential worker protections. The proposal allows this option only when care directly from VA or from a non-VA provider with a FAR-based agreement in place is not feasibly available. Already, we have seen certain nursing homes not renew their agreements with VA because of the excessive compliance burdens, and as a result, veterans are forced to find new nursing home facilities for residence.
VA further requests your support for our efforts to recruit and retain the very best clinical professionals. These include, for example, flexibility for the Federal work period requirement, which is inconsistent with private sector medicine, and special pay authority to help VA recruit and retain the best talent possible to lead our hospitals and healthcare networks.
4. *Special Legislation for VA's West Los Angeles Campus*: VA has requested legislation to provide enhanced use leasing authority that is necessary to implement the Master Plan for our West Los Angeles Campus. That plan represents a significant and positive step for veterans in the Greater West Los Angeles area, especially those who are most in need. We appreciate the Committee's hearing in December 2015 on legislation to implement that Master Plan, and VA urges your support for expedited consideration of this bill to secure enactment of it in this session of Congress. Enactment of the legislation will allow us to move forward and get positive results for the area's veterans after years of debate in the community and court action. This bill would reflect the settlement of that litigation, and truly be a win-win for veterans and the community. I believe this is a game-changing piece of legislation as it highlights the opportunities that are possible when VA works in partnership with the community.
5. *Overhaul the Claims Appeals Process*: As mentioned earlier, VA needs legislation that sets out structural reforms that will allow VBA and the Board to provide veterans with the timely, fair, and quality appeals decisions they deserve thereby addressing the growing inventory of appeals.

Lastly, let me again remind everyone that the vast majority of VA employees are hard workers who do the right thing for veterans every day. However, we need your assistance in supporting the cultural change we are trying to drive. We are working to change the culture of VA from one of rules, fear, and reprisals to one of principles, hope, and gratitude. We need all stakeholders in this transformation to embrace this cultural transformation, including Congress. In fact, I think Congress, above all, recognizes the policy window we have at hand and must have the courage to make the type of changes it is asking VA and our employees to make. Congress can only put veterans first by caring for those who serve veterans.

Our dedicated VA employees, if given the right tools, training, and support, can and go out of their way to provide the best care possible to our veterans and their families.

CLOSING

VA exists to serve veterans. We have spent the last year and a half working to find new and better ways to provide high quality care and administer benefits effectively and efficiently through responsible use of taxpayer dollars. We will continue to face enormous challenges, and this budget request will provide the resources needed to continue the transformation of this Department.

This budget and associated legislative proposals will allow us to streamline care for veterans and improve access by addressing existing gaps, develop a simplified appeals process, further the progress we have made to eliminate the VBA claims

backlog and end veteran homelessness, and improve our cyber security posture to protect veteran and employee data. It will also allow us to continue implementing MyVA to guide overall improvements to VA's culture, processes, and capabilities.

I have pledged that VA will ensure that the funds Congress appropriates to VA will be used to improve both the quality of life for veterans and the efficiency of our operations. I am proud to continue this work and recognize there is much left to be done. We have made great strides and are grateful for the support of Congress through this transformation.

Thank you for the opportunity to appear before you today and for your continued steadfast support of veterans. We look forward to your questions.

HINES VAMC SCHEDULING MANIPULATION INVESTIGATION

Senator KIRK. Let me start the questions here, and say, Mr. Secretary, Ms. Germaine Clarno is a social worker at the VA hospital in Hines, Illinois. She has been calling for the VA to fix failures at the hospital for years.

I introduced you to Germaine in Chicago in January of 2015 and again in my office on April 21, so you know her. It was 11 months after I asked your predecessor, General Shinseki, to investigate the allegations of Ms. Clarno at the Veterans Hospital in Hines similar to the scandal at the Phoenix VA, all to acquire bonuses and promotions.

This is why I called for the resignation of Joan Ricard, the person who led the Hines VA, and then she retired.

Fourteen months after my call to General Shinseki on July 20, 2015, your chief of staff, Rob Nabors, concluded that the Inspector General investigation had "thoroughly addressed the concerns of the complainant Germaine Clarno" as summary number one. In response, both Germaine and the Office of Special Counsel (OSC) asked for the full Inspector General investigation report. That was 7 months ago.

Summary number two of the Inspector General investigation on Hines' scheduling manipulation also came from the Inspector General on September 8. And in response, 2 weeks ago, the OSC wrote President Obama on the Hines investigation that the report was "incomplete" and "not responsive," did not respond to the whistleblower's concerns raised and "did not meet the statutory requirements," and was, "not responsive to the serious allegations of significant wait times and delays in the veterans' access at Hines." It also said, "it demonstrated hostility" toward Ms. Clarno apparently for having spoken publicly, as well as an attempt to minimize her allegations.

Again, summary number three was released, but not a report with the VA's instructions for change.

Secretary McDonald, the VA-MilCon section of the funding bill of the omnibus did require all "work products" to be transmitted to the Appropriations Committee. I would ask you if you have brought this full report, and I would like you to bring the full report to the subcommittee as required by law, which would really help Ms. Baldwin on the candy factory at Tomah to get the complete Inspector General report, as required by law. I have also discussed this with our ranking member, Mr. Tester.

Secretary McDONALD. Mr. Chairman, we want all of the Inspector General reports to be released. In fact, as you properly pointed out, I have met with Ms. Clarno on numerous occasions. We appreciate her coming forward and describing what was wrong at Hines.

As you properly pointed out, these investigations occurred in the middle of 2014 before I was confirmed. The President has nominated a new Inspector General, and we would like the Senate to immediately confirm that new Inspector General, Mike Missal, because we have a lot of work to do with the Inspector General to get these reports out.

Also, in the letter that you referenced from the Inspector General, if you read the next paragraph, the Inspector General says that she is optimistic that this new Inspector General will conduct more thorough investigations in a more appropriate and comprehensive direction for the Department.

Our Deputy Secretary is digging into all of these issues and sorting out the differences in opinion between the Inspector General report and between the Office of Special Counsel. We are working with both parties to do that. As soon as we are done doing that, we will get back to [you] immediately.

But again, I just want to say we appreciate Ms. Clarno pointing these things out.

Senator KIRK. She is sitting right behind you there.

Let's keep going. Mr. Tester.

Senator TESTER. Thank you.

INSPECTOR GENERAL CONFIRMATION

Just very quickly, Secretary McDonald, what you are saying is that if Mike Missal can get confirmed, you could get that information to us quicker?

Secretary McDONALD. Yes, sir. I think we have been short-staffed at the Inspector General since the Inspector General retired.

Senator TESTER. So it is important. I believe he is cleared on our side and so if, Mr. Chairman, if you and the other members of this subcommittee can make that plea to your caucus to take off the hold so we can get him confirmed, it could make a big difference.

I think it is important we get this report. I think we need to get the good information on this report and get it as soon as possible, so I support the chairman's efforts here, but you guys need the tools to be able to do that. So please help.

BETTER CARE IN THE COMMUNITY LEGISLATION

As I said in my opening, I am working on a bipartisan piece of legislation, a number of issues including provider agreements, spending flexibility that will allow you to provide better care in the community in a timely manner.

Can I get a commitment from you, Mr. Secretary, that you will help get this bill across the finish line, particularly with the VA Committee?

Secretary McDONALD. Yes, sir. I believe we are doing that Tuesday.

Senator TESTER. Would you agree that if we do not get that bill done, that it could have a dramatic impact or continue the kind of impacts we are having on veterans right now with Choice?

Secretary McDONALD. Yes, sir. One of the reasons our service is so bad with a third-party administrator, like Health Net, is resolved in this bill.

Senator TESTER. Okay, good. That is good. Thank you for that.

2018 ADVANCE APPROPRIATION

Last week, when Dr. Shulkin was here, we questioned him about a gaping hole in the fiscal year 2018 advance appropriations for medical care. You are going to get a second bite at this apple, but this is going to be a big bite.

My understanding is the VA's future costs for all hires under the Choice Act is \$1.3 billion and the future costs for leases and activation is about \$318 million. None of these costs have been built into that 2018 advance request. Is that correct?

Secretary McDONALD. Yes, sir.

Senator TESTER. Okay. So on top of that, between the Choice Act funds and discretionary appropriations, I think you are planning on spending about \$12 billion on Care in the Community in fiscal year 2017. Your head is nodding, so I assume that is correct.

But in 2018, the advance appropriations request for Care in the Community is about \$9.4 billion. I hope you can track these numbers. You know them. That is almost a \$3 billion reduction, and Choice funding will probably be exhausted by then. How are you going to make up the difference?

Secretary McDONALD. I think, again, you mentioned the second bite idea, but I think the issue here, Senator Tester, is we have to know what we are actually going to provide before we can cost it out. That is why Tuesday's hearing with the authorizing committee is so important, because if we can deal with your bill, your consolidation bill, consolidation of Care in the Community from the seven different methods to one, we will know exactly how to cost it out.

But as you know, there are choices within that bill, there are choices available, so we are waiting to see what the authorizers authorize. Then we will know exactly what the cost will be.

Senator TESTER. So you know, and I think you probably know this, the nondefense discretionary cap is going to be \$3 billion lower than it is this year, so we are going to get a double whammy off this thing, if you know what I mean.

So we look forward to making sure we do not have a shortfall in your monies.

SES EXECUTIVES TO TITLE 38

Mr. Secretary, you put forth a proposal that would allow the VA to move all of its senior executives to title 38. Can you explain how this move will impact the accountability at your Department?

Secretary McDONALD. The idea of moving our Senior Executive Service staff to title 38 was to help us recruit, because we would have direct hiring authority. It was to help us pay more competitively. Most of our medical center directors make less than 50 percent of what they can get from the private sector, because they are Readjustment Counseling Service (RCS) employees.

It would also have the appeal authority for disciplinary actions within the Department, so I would be the appellate authority rather than the Merit Systems Protection Board (MSPB).

In working within the executive branch, we have come to the point of view that that is appropriate for medical people in the Veterans Health Administration (VHA), but there is some pause

whether or not we should apply that it people in the [Veterans] Benefits Administration.

Senator TESTER. Would it make a difference in accountability?

Secretary McDONALD. We are coming up with a proposal, which we will share with you on Tuesday, that would make a difference in accountability, yes, sir.

SIMPLIFIED APPEALS PROCESS PROPOSAL

Senator TESTER. Okay. You put forth a proposal, very quickly, on the appeals process.

Secretary McDONALD. Yes, we have.

Senator TESTER. Have you contacted the Veterans Service Organizations (VSOs) on that proposal?

Secretary McDONALD. We have had people locked in the room this week, including Veterans Service Organizations, AHF members, working on the proposal.

Senator TESTER. So you cannot tell me whether they support it or not at this point in time?

Secretary McDONALD. I think it is safe to say that they support most of the elements in the proposal. I think the most difficult element in that proposal is freezing the form 9, which would cause a veteran to reapply.

Senator TESTER. All right. Thank you.

Thank you, Mr. Chairman.

Senator KIRK. Ms. Collins.

Senator COLLINS. Thank you, Mr. Chairman.

ACCESS RECEIVED CLOSER TO HOME

Mr. Secretary, welcome. We have discussed many times the ARCH (Access Received Closer to Home) program, which exists in northern Maine, which is one of the five pilot sites across the country. This program, as you well know, allows veterans in rural areas to receive exceptionally high-quality care close to home, close to their families, and when they need it.

It has a 90 percent patient satisfaction rate. And according to the VA's own figures, the average cost per veteran in Maine using the ARCH program is less than the average cost for the VHA direct care.

This is a program that has been very well-received. It has been extremely well-operated. And it contrasts sharply with the experience that Maine veterans have had with the Choice program where fewer than 50 percent of eligible Choice program patients in Maine have received the appointments they need when they need it. And the contractor chosen by the VA, Health Net, has performed very poorly in my State.

Given the huge success of the ARCH program and how happy our veterans are with it, and how cost effective it is, I do not understand the resistance of the VA to preserving the program.

I hear all of this discussion of folding ARCH into the Choice program. To me, ARCH ought to be the model for the Choice program. ARCH is working, working well. The Choice program is not working well.

So will you consider extending the ARCH program in its current form, so that we are not taking a program that is working well and breaking it by folding it into a program that is not working well?

Secretary McDONALD. Senator Collins, the new program that we are talking about, taking the seven different ways of achieving care in the community, including ARCH, and consolidating them into one is not consolidating them into the old Choice program. It is creating a whole new program that takes the benefits, the things we learned from the ARCH pilot, and folds them into a wholly new program that provides care in the community in one way with one reimbursement rate.

So I think we should look at the bill Senator Tester has authored and others in our authorization committee have all have authored as a wholly new program that will take everything we have learned from Choice and from ARCH and actually consolidate it in a new program that will make things easier for veterans and make things easier for our employees.

David, would you like to comment?

Dr. SHULKIN. Senator Collins, I think you are accurate. The ARCH program predated Choice. It has worked extremely well.

As you know, it is a relatively small number of veterans. I think in the State of Maine, it is about 1,400 veterans. It is pretty small.

So that idea of expanding the ARCH program to be this consolidated program is one that we have looked at. But the cost of that would be extraordinary because, as you know, ARCH was meant to get veterans access in rural areas, in areas where there are provider shortages. So we tend to have a reimbursement rate for providers that would be really unsustainable for the rest of the country.

So we are trying to preserve what has worked in ARCH in this new Veterans Choice program.

Senator COLLINS. Well, let me just point out that the hospital, Cary Medical Center, that is administering the ARCH program is paid at Medicare reimbursement rates. And according to the VA's own figures, the average cost per veteran in Maine using ARCH is \$2,708.70—a pretty precise number—which is less than the VHA direct care.

So my concern is that you are going to cause disruption in a program that has been cost-effective and has worked very well. That is what I am really worried about.

I just cannot overstate how satisfied the veterans are with this program.

My time has expired, and I know we have a vote. I have an important question on the opioid problem and the prescriptions that are prescribed by the VA. The risk of death by accidental overdose among patients at the VA facilities is nearly twice that of non-veterans, so I would ask to submit that question and others for the record.

Thank you.

Senator KIRK. I think since we have a vote that has just been called, we will take a short recess.

[Recess.]

Senator MURKOWSKI [presiding]. At this time, I will turn to Senator Hoeven.

VETERANS CHOICE IMPROVEMENT ACT

Senator HOEVEN. Thank you, Madam Chairman.

Mr. Secretary, good to have you here.

We need to improve the Veterans Choice Act. That is why I have worked with Senator Burr and others to introduce the Veterans Choice Improvement Act. We are looking to combine that with the work that the VA Committee has already done, which includes legislation that I have crafted relative to long-term care and in-home care, combine that with healthcare.

We are looking to bring all this together and move it as soon as we can. You and I have talked about this.

Secretary McDONALD. Yes, we have.

Senator HOEVEN. But this provides the important flexibility so that you can not only provide quality institutional care within the VA for veterans that want to access that, but also so that we make the Veterans Choice Act work.

We have a big problem with these third-party service providers, like Health Net, that are not providing quality service, and that is giving Veterans Choice a bad name.

So we have an opportunity here to make this thing work, but we have to figure out how to do it. This legislation empowers you to do that.

CHOICE THIRD PARTY SERVICE PROVIDERS

So what I would like you to respond to is how you intend to handle these third-party service providers.

Secretary McDONALD. Over time, I think what we need to do, and this is why a change in legislation is so important, is change the contractual relationship with third-party service providers.

I think we can't outsource customer service. In my opinion, that was the big mistake with the original Choice Act. We basically just outsourced customer service to the third-party providers. So the third-party provider, we would literally just give the veteran a phone number to call. That is just not right.

I mean, we are in the customer service business. Our vision is to be the best customer service organization in government. We should not be outsourcing customer service.

We have to change that relationship. That is part of what the new law, that we are very appreciative for, would do.

David.

Dr. SHULKIN. Senator, the other thing I would say is, as you know, the Choice program, we had to bring it from conception to start in 90 days, so it was a very short time period. What we have been doing since then is we have been meeting with private industry, mostly the managed care industry and the outsourced industry, and getting the very best practices and the very best thoughts so that we can develop a request for proposal (RFP) when we go out under the new Veterans Choice program to have a much better program that is really state-of-the-art.

Senator HOEVEN. Then one of the keys is that this legislation will also give you the ability to provide that service directly. In other words, the VA itself work with veterans to go to private healthcare providers. I think that is a very important piece.

For example, in our State, with the Fargo VA Health Care Center, which serves all of North Dakota and most of Minnesota, they have a very good reputation for providing quality care. You have a director there, Lavonne Liversage, who has people in her customer service area that can work with private healthcare providers, and she is willing to do that. Thank you for committing to come out and help us set that up.

So, one, are you willing to let us set up that kind of approach to show that it works? I think you have already done it in Alaska, in Montana. We need to be able to do it.

Then will you keep that option, which we allow you to do under the legislation? So if you want to go bid for a service provider and not work for somebody, well, that may be okay, but we can also do it directly so we can ensure that our veterans get that access to quality care, whether it is at the VA or through a private healthcare provider.

Secretary McDONALD. Senator, that is exactly what we want to do. We envision an optimized network of great providers all across the country, so that the issues that Senator Murkowski, for example, has raised in Alaska, where the Choice program cut out the Alaska Native Health system, we can get them back in, because they are great providers, they are great partners of us, and we would like to be able to develop that optimized system rather than only having one entrance door for the veterans, which is "call this phone number."

So that is exactly what we have in mind. We appreciate your advocacy for it.

Senator HOEVEN. Than the other piece, if you would touch on for a minute, is we have worked to include legislation that enables nursing homes and other providers of long-term care, including in-home care, the ability to get provider status in a way that works for them without a lot of red tape and bureaucratic complications.

LONG-TERM AND HOME CARE

Are you willing to support that and help us institute that? That is going to give veterans long-term care and in-home care in their communities. They can still go to the veteran center in their State if they want, but it gives them that access to care in the community, long-term care.

Secretary McDONALD. We are very much appreciative for you introducing that bill. We need these provider agreements. Right now, we have providers around the country who are refusing to do business with us because of the Federal Acquisition Rules, and the cost, the red tape that that adds to their operation. These small businesses can't afford that. We have, in some cases, where they are literally threatening to throw our veterans out of their homes because they do not want to do this red tape.

So this bill would give us the ability to continue to do business with them and lessen the Federal Acquisition Rules red tape for them.

Senator HOEVEN. Thank you, Mr. Secretary.

And, Dr. Shulkin, thank you as well. I appreciate it.

Senator MURKOWSKI. Thank you, Senator Hoeven.

Senator Cassidy.

VA HEALTHCARE STAFFING PRODUCTIVITY TO PRIVATE SECTOR

Senator CASSIDY. Dr. Shulkin and I had a conversation the other day regarding best practices, productivity, mental health. But again, kind of continuing on the theme that I speak to colleagues, physician colleagues, who work in VAs around the country, I am told by some that they may see two patients an hour.

So I mentioned your staffing, some of your budget for staffing, and their productivity is far less than private practice. Now, that is important, because obviously the doc is—but I am sure it is true for the nurse practitioner (NP) and physician assistant (PA), et cetera.

So first question is, to what degree is the physician productivity, the PA, the NP productivity, less than the private sector, both on an average per doc and then collectively across the system?

And then I guess the next step would be, as we are talking about staffing, it seems like the better step would be to first get your systems down so that the physician is seeing 20 or 30 patients a day instead of 14 patients a day, which I gather it is sometimes even less than that.

So I will toss that out.

Secretary McDONALD. Senator Cassidy, we measure productivity, and we track it very closely. We use the common industry practice of relative value units (RVUs). Our productivity is up roughly 9 percent to 10 percent over the last year.

I would argue that the reason, on an absolute level, we may seem more less productive is, one, our patients have much more complex situations.

Senator CASSIDY. Now can I challenge you a little bit on that?

Secretary McDONALD. Surely.

Senator CASSIDY. Because you are going to have in the mix the follow-up. I used to see very complex patients and so for one I would have booked out a 45-minute or even an hour visit, but it would later come back as a 5-minute visit or even my nurse walking in, giving the results, and me making sure there are no questions. So that we I could see four patients in an hour, five patients in an hour.

Some I am going to challenge you little bit, because they are not very complex every single time.

Secretary McDONALD. I agree. They are not very complex every single time.

Also, our providers work on a team basis in order to do a lot of alternative therapies that you would not see in the private sector.

For example, if our primary care physician and our mental health professional discover the person has posttraumatic stress, they may then work with them to get them into acupuncture or yoga or some—

Senator CASSIDY. But that can only be—this limited time, so I am sorry to interrupt.

That can only be 5 percent or even 10 percent of your patients. Most of it is going to be straightforward diabetes, hypertension, cholesterol check, lab check.

Secretary McDONALD. Well, when I look over the productivity numbers, this is what I see.

David practices, so maybe he has a different point of view.

Dr. SHULKIN. Yes, Senator Cassidy. First of all, we do measure on RVUs. The Secretary is correct.

We have increased productivity 10 percent over the past 2 years. But now I have some greater insights into what you are talking about, since I now have begun to practice as an internist in the VA.

I get 30 minutes for a follow-up, an hour for new patient. What you see when you practice in the VA is we are doing a much more comprehensive approach toward preventative care, screening for depression, screening for opioid abuse, substance abuse.

So the care that we are delivering in the VA is one of the reasons why we have such better quality metrics than in the private sector.

Senator CASSIDY. So can I ask?

Dr. SHULKIN. Yes.

Senator CASSIDY. So again, just going to my field, which was managing ascites, for example, sometimes I would see them every 2 to 3 weeks, just to counsel on whether they are on a sodium restriction, checking creatinine, et cetera.

If I got 30 minutes for every visit every 2 weeks, that would just gobble up my schedule.

Dr. SHULKIN. Right.

VA PATIENT SCHEDULING SYSTEM

Senator CASSIDY. So is it automatic, because in your GUI, by example, graphical user interface, it has a 30-minute block for everybody. So no matter the complexity, is it possible to make three patients each 10 minutes or is every single patient 30 minutes?

Dr. SHULKIN. Our scheduling system is pretty fixed.

Senator CASSIDY. So that, I have to tell you, I used to do a pretty good job of preventive health, so I will not concede that you must be so wasteful with time in order to accomplish everything. Would you agree with that?

Dr. SHULKIN. I agree, and I do think it is worth us looking at that, having a brief visit.

Senator CASSIDY. I have to imagine that you could increase the productivity of your physicians dramatically in both number of patients per physician as well as—we do not need to hire more, by golly, we now have it, just by kind of allowing somebody to say this is really just a follow-up to make sure they are taking their fluid pills.

Dr. SHULKIN. I think we are looking at all of these things since access is our top priority. So you are identifying something that absolutely is worth looking at.

I think the Secretary is also correct. What most of our VA doctors are saying to us is, give us some additional team-based help. Give us the RNs, the pharmacists, the social workers to be able to use our time more productively, to be able to get patients through faster. So it is going to be multifactorial.

I can assure you, we are laser-focused on increasing access and productivity right now, and we are going to take your comments back about seeing whether we can adjust for some brief visits as well, because I agree with you. There are many patients who come back for simple reasons.

Senator CASSIDY. Okay. I yield back. Thank you.

Senator MURKOWSKI. Thank you, Senator Cassidy.

I am now going to turn to Senator Baldwin, and I am going to pop out and go vote. I am sure we have other members who are coming back, so you may get more than 5 minutes.

Senator BALDWIN. [Presiding.] Oh, terrific. I hope everyone is as pleased as I am about that opportunity.

Secretary McDONALD. We are.

JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

Senator BALDWIN. Especially since I want to start with a thank you, Mr. Secretary. I very much appreciate your support for the legislation that I drafted, along with Senator Capito.

I know you are well-familiar with the Jason Simcakoski Memorial Opioid Safety Act that passed out of the Veterans' Affairs Committee late last year. I will also note that the chairman of this subcommittee, Ranking Member Tester, Senator Murray, are also cosponsors of the bill.

We hope that this bill will pass the Senate and become law in short order, and I hope that we can count on you for your continued support and advocacy, Mr. Secretary, to help us move this across the finish line.

Secretary McDONALD. For sure. I believe that we have a leading role to play in American medicine in showing the way forward on reducing opioid use and also in preventing suicide.

Senator BALDWIN. I appreciate that very much.

I want to turn your attention to an issue that has recently been subject of many media accounts in my State.

When I am not the only person here, I will ask unanimous consent to add a number of articles for the record, or maybe I can just—

Secretary McDONALD. I think you are the chairwoman right now.

Senator BALDWIN. I am in charge, so I ask unanimous consent to enter several news articles in the record. We will hold the record open so somebody can object if they would like, but I doubt it.

[The information follows: the requested information was not available at the time this publication went to print.]

SOCIAL SECURITY NUMBERS AS IDENTIFIER TO VETERANS' RECORDS

Senator BALDWIN. Anyways, quite seriously, these articles detail an incident that occurred last year in Wisconsin when a VBA employee sent to VSOs at the Wisconsin Department of Veterans Affairs a spreadsheet that identified 638 veterans whose claims had been recently closed.

Mr. Secretary, because the spreadsheet contained veterans' names and Social Security numbers, it was encrypted before transmission.

I apologize [that I] am going to get into the weeds here, because I really want to make sure that the facts of what happened become a part of this record.

Thereafter, one of the VSOs who received the spreadsheet from the VA forwarded that email to a number of State and county VSOs so that they could reach out and offer assistance to the veterans listed. Because the recipients were not affiliated with the VA

and did not have VA email addresses to which encrypted emails could be sent, the VSO's message was sent unencrypted.

In addition, although the VA security tools and procedures generally prevent the emailing of personally identifiable information without encryption, this transmission was nevertheless successful because the content did not meet the criteria that would have otherwise prevented transmission.

One recipient included a veteran who is not a VSO or a representative of any of those listed individuals. That individual and his representative alerted the Wisconsin Department of Veterans Affairs, the media, and my office concerning the problem.

Mr. Secretary, we can certainly have quite a back-and-forth about whether the VA bears some responsibility for what happened, but what I would like to see is the VA discontinue using Social Security numbers to identify individuals in all information systems. Until that is done, veterans will be at risk for identity theft and fraud.

I am going to ask you, Mr. Secretary, what your thoughts are on this proposition.

Secretary McDONALD. I would have to take a closer look at it, but I can tell you that we take the disclosure of personal information very, very seriously, even to the point that we always fault on the side of the veteran. So this is a very unfortunate circumstance.

I know there was an issue with our software that if the numbers were strung together without the hyphens, and you and I are both getting into the weeds on this, that it could go out, even though it is a Social Security number.

Senator BALDWIN. Right.

Secretary McDONALD. I know we have taken immediate steps to fix that, but going all the way to using some other mechanism other than Social Security numbers to identify an individual, I would have to get back to you on that.

[The information follows:]

[From Channel3000.com, WISC-TV, News 3, Madison, Wisconsin]

(By Adam Schrager)

MADISON, Wis.—The Social Security numbers of Wisconsin veterans are being sent via email without encryption despite numerous Federal laws and U.S. Department of Veterans Affairs regulations requiring personally identifiable information be password-protected.

It partly explains how a random Wisconsin veteran received an unsolicited email on April 1 with the Social Security numbers and disability claim information of hundreds of Wisconsin veterans. Since the Vietnam War, veterans' file numbers or disability claim numbers have been their Social Security numbers.

"I got up, was working at the computer and had an email from the Department of Veterans Affairs in Wisconsin. Not knowing what it was, I opened up the attachment and I panicked," the veteran said. "It was nine-digit numbers. There were no hyphens. It wasn't like 111-11-111. It was nine numbers straight."

A Wisconsin Department of Veterans Affairs spokesperson said the software program, Ironport, which is used by the Federal VA, intentionally does not flag nine-digit numbers without dashes because of the concern that there would be too "many false positives." She said nine-digit number sequences where dashes are used would require the person sending the email to encrypt it before it could be sent or to remove the nine-digit number sequence with the dashes.

The veteran who received the email immediately notified the Wisconsin Department of Veterans Affairs of its error. He forwarded it, with the attachment, to his

advocate, a retired colonel who used to work for the WDVA. Together, they notified numerous elected officials and the Federal VA about what had happened.

"There is absolutely no reason in the world for me to have this information," he said. "We were told it was an error. We should not have received that."

The veteran and his advocate sent an email to the WDVA a week after the privacy breach stating they would assure the department that they "(had) not forwarded this very confidential information." Kim Michalowski, who was in charge of the WDVA office that sent the email, thanked them in a follow-up email for their "assurances."

However, any good will between the parties soured when the WDVA, and subsequently the Wisconsin Attorney General's Office, demanded the veteran and his advocate destroy all records associated with the privacy breach. The veteran responded in an email obtained by News 3 that multiple groups were investigating the matter and he wanted to know if he was being asked to "destroy evidence."

His answer came less than a month later when he and his advocate were sued in Dane County Circuit Court, in an effort to compel them to destroy all evidence of the email and the attachment. The veteran and his advocate sought legal counsel, paid to completely scrub their computers and were forced to sign an affidavit that they had no record any more of the email and its attachment before the lawsuit was subsequently dismissed.

"We were told we had to clean them off the computer, off all servers, off the cloud. My God, how do I do that? I can barely turn on a computer," said the veteran, who is remaining unidentified because he is fearful of further retaliation. "I believe the process needs to be rectified. We have very dedicated veterans out there who need to have their privacy, their security, respected, and when this kind of information is released unsolicited, that's a travesty."

Nine days after the email was sent, WDVA Secretary John Scocos sent a note to the 637 veterans whose names and file numbers were in the attachment offering credit monitoring for a year and said the incident was a "one-time disclosure to one unauthorized individual, who is a Veteran." However, less than a week after that, the department's own investigator determined that the data report inappropriately sent on April 1 had also been sent to "unaccredited recipients."

"The email filter, on the U.S. Department of Veterans Affairs computer network, which typically alerts the sender to this type of disclosure did not block the sensitive data in this instance," WDVA Communications Director Carla Vigue wrote in a statement emailed to News 3. "When we contacted the USDVA Network Security Operations Center regarding this occurrence, they were already aware of the problem of certain emails making it past the filter."

News 3 has learned the April 1 incident is not an isolated one. On at least three other occasions (June 1, 2014, Oct. 1, 2014 and Dec. 1, 2014), the same data report was also sent unredacted to "unaccredited recipients," or as defined by the VA, people who are not trained to view such personally identifiable information. In fact, the administrator doing the internal investigation is himself "unaccredited," according to USDVA documents, and thus, not supposed to look at personally identifiable information of Wisconsin veterans such as the material erroneously sent.

Combined, the four data reports contained the disability claim numbers of nearly 2,000 Wisconsin veterans. An open records request to learn who received the emails from June 1, 2014–April 1, 2015, has not been answered by the WDVA.

"The WDVA has tightened protocols regarding privacy to safeguard sensitive information," Vigue wrote. "We no longer share the report in question."

The internal investigation recommended Michalowski and his subordinate, Colin Overstreet, who actually sent the email, be suspended for one day. Both have since left their positions at the WDVA. Neither Michalowski nor Overstreet agreed to comment on what happened.

Multiple requests for an on-camera interview with Scocos were denied. An on-camera interview with his deputy, Kathy Marschman, was canceled less than two hours before it was scheduled. In a meeting to discuss an interview, Marschman said protecting the personally identifiable information of Wisconsin veterans was one of the department's top priorities, but a review of the department's 2015–16 strategic plan does not mention that.

Secretary McDONALD. Danny, do you have any?

Mr. PUMMILL. The only thing I would add, Senator, is that when the list was sent out unencrypted, we should not have relied just on the computer software to catch the serial number sequences of the Social Security numbers and stop it. The individual should not

have sent out an unencrypted list to anybody with Social Security numbers on it.

We put extra emphasis on that. We check it constantly now, and we reiterate to everybody that it is personal responsibility. You do not rely on software. Under no circumstances do you send a Social Security number unencrypted.

But we are looking at other ways of modifying it. As you know, the VA claim number is actually the Social Security number of the individual, and we are trying to find an alternate way of doing that.

Senator BALDWIN. I hope to work with you in that process. Other major governmental agencies have made the change from using Social Security numbers as identification numbers to alternatives. I understand the scope of that undertaking with agencies as large as the VA.

But I just want you to know that we are drafting legislation and seeking your technical assistance. We are getting that technical assistance, and I hope that we can be partners in this effort as we move forward.

Secretary McDONALD. May I say, Senator, that one of the things we are undertaking right now is we do not have a single data backbone within VA, so if you are a veteran and you want to change your address, you have to do it in about eight different places, nine different places. One of the things we have taken on with our new Chief Information Officer (CIO), LaVerne Council, who is sitting behind me, is creating that single data backbone.

That would be a great opportunity to move away from Social Security numbers, because we could put some other kind of identifier there, and it would simplify everything.

Senator BALDWIN. Well, I am all for seizing opportunity, so I look forward to continuing to work together on that.

As temporary chair of the subcommittee, I would be happy to now recognize my colleague, Tom Udall, for questions.

Senator UDALL. Thank you very much, Senator Baldwin.

Secretary McDonald, it is so good to see you here, and accompanied by Dr. Shulkin and Mr. Pummill. Thank you, all of you, for your service to the country and to our veterans. There could not be a more important task that we undertake.

I fully respect the fact that you took this assignment, Mr. Secretary, at a difficult time during great publicity around a serious scandal. Working with Congress and additional resources, I think you have made some good progress, including yesterday's announcement that the VA is now able to fund care for all veterans with hepatitis C. That is a very, very welcome development there.

We are going to have to keep that up to regain and maintain the trust of America's veterans, and I know that you all are committed to that.

I was pleased to meet with you 2 weeks ago and talk about some of the issues with VA care in New Mexico.

I am also glad to see that the VA budget justification specifically supports research and exposure to airborne particulate matter from burn pits. I look forward to an update on this research as it moves forward on how we can ensure veterans get the treatment they need for such exposure.

The hearing today is important to discuss ways to improve the department and its services for veterans. The subcommittee, as you know, funds your agency and we ensure that this essential care is ready to support more veterans and, in particular, the new veterans who are coming home from Afghanistan and Iraq. We need to make sure that there is a seamless transition there.

RECRUITMENT OF VA MEDICAL STAFF

Now, my first question, as you know, access is essential and can be particularly difficult in rural areas like New Mexico, partially due to problems with retaining practitioners. How does this budget aim to recruit talented medical staff in VA facilities? And what can be done, in your opinion, to either incentivize or streamline the process to hire new doctors and nurses?

Secretary McDONALD. Senator Udall, as you and I have talked before, having the providers in place is hugely important. I have been to over two dozen medical schools myself recruiting, and we have hired over 1,400 doctors since I have been Secretary.

Nevertheless, I think we have a shortage of medical schools in this country and one of the things I think also, VA has a shortage of osteopathic doctors, which is a lost opportunity.

So I would like David to talk about this. We are increasing, ramping up, our recruiting of osteopathic doctors and all kinds of doctors nationally in order to recruit them and get them to particularly operate in rural areas. We know that osteopathic doctors are more willing to live in rural areas. They are also more primary care than specialty, which is exactly what we need.

Senator UDALL. Dr. Shulkin, please proceed.

Dr. SHULKIN. Yes, thank you.

I think the Secretary is right. We are looking to explore all avenues. The osteopathic physicians are certainly one avenue that we are really working hard at, making those relationships.

We have added new residency affiliations with osteopathic medical schools, and we are looking to enhance those relationships. We now have about 300 osteopathic trainees in the VA healthcare system, and we are looking to expand that.

In addition, because of your support through the Veterans Access, Choice and Accountability Act (VACAA) legislation, we have been able to expand residencies desperately needed for American medicine. When they have a great experience in the VA, they tend to want to stay in the VA healthcare system. So we are working on that.

We are using educational debt reduction programs to help young physicians come in and stay in the VA. That is an incentive.

And we are looking at our compensation pay tables to make sure that we are adjusting the pay, particularly for physicians that we have a very difficult time recruiting in rural areas.

But any help that you could provide us, any ideas that you have that we are not exploring, particularly with primary care and mental health in rural areas, we really could use additional help.

Senator UDALL. I was very excited to hear that you all are working with medical schools and standing up medical schools and additional residencies, which really make a difference.

As I have told you, we have a new osteopathic school that is about ready to get going in southern New Mexico that we hope you will work with.

INSPECTOR GENERAL MISSAL NOMINATION FOR APPROVAL

I want to shift over here to the Inspector General, because you have asked, and Senator Tester has said, and other others on the subcommittee have said, how important the Inspector General is. I would echo what the others have said.

We have to approve your Inspector General. Nothing pushes that idea more than the fact of what happened as you were coming in.

I worked in New Mexico, I had many people approaching me and saying there are problems going on, there are scheduling problems, there is this, there is that. We did not have the expertise to deal with it, but we were able to take the information, work with the complainants, get them into the Inspector General, and then have the Inspector General work with them and do a report to you. So I think we need to find a way.

I would call on everybody to remove those holds and put the Inspector General in place for the Veterans Administration.

How do we strengthen employee trust in the VA Office of Inspector General (OIG) operation?

Secretary McDONALD. One of the things we have done is through our Leaders Developing Leaders program, which I discussed earlier, we have taken our top 450 leaders offsite. We have done 3 days of training. Part of that training is in values and, importantly, in the values of the Inspector General and the role the Inspector General plays.

We have also tried to partner with the Inspector General, so we are working together. So we are helping the Inspector General identify trouble spots, because during the time of change, like we are having with the transformation, the MyVA transformation, that can create challenges for us. So we want the Inspector General to be vigilant on where those challenges are.

But just for an example, we have had over 110 investigations just on scheduling alone. Of those 110-plus, only 77 have been completed. Of those 77, we have had roughly 10 sites that have been discovered problematic, and 28 individuals that we have had disciplinary action against.

So it shows you the enormity of what we are talking about and also the fact that we are not done yet. We still have a lot of work to do.

ALBUQUERQUE VAMC MEDICAL INVESTIGATION REPORT

Senator UDALL. Secretary McDonald, just one more brief question. I understand that you recently signed off on a medical investigator report pertaining to the Albuquerque VA medical center. Can you provide the details of the three recommendations contained in the report? And when will you be able to share that report with me and release it publicly?

Secretary McDONALD. I think David has the report, Senator.

Dr. SHULKIN. This is concerning allegations with the appropriate use of using psychological testing, particularly for traumatic brain injuries. We have seen the initial draft report.

We will be able to get you a specific date that it will be able to be released to you and make sure that we do that. In fact, I think we may be able to get you a redacted report even sooner than its official release date. We will be glad to do that.

I will tell you that when I have reviewed the report, I am comfortable with the findings in terms of what was substantiated and what was not substantiated, so that we do not feel at VA that we need to take immediate action right now for patient safety, or else we would be taking that action.

[The information follows: the requested information was not available at the time this publication went to print.]

Senator UDALL. Great. Thank you, Dr. Shulkin, very much.

I will submit my additional questions for the record, because my time has expired. One is on 3-D printing and the other is on Comp and Pen, which I think you all have discussed very thoroughly here.

I yield back, Mr. Chairman.

Senator KIRK [presiding]. Thank you, Mr. Udall.

HINES VAMC WAIT TIMES DATA

I requested all documents the VA had about wait time abuse at Hines VA. Did you bring those documents?

Secretary McDONALD. I do not have them with me, Senator, but we will get them to you.

David may have them.

Dr. SHULKIN. Senator, I apologize. I did not see a specific request from you, but I do have the current wait times data at Hines VA that I will be glad to leave with you and share with you.

Senator KIRK. Thank you.

HINES VAMC INSPECTOR GENERAL INVESTIGATION

As I mentioned earlier, the Office of Special Counsel wrote to the President in defense of Germaine Clarno, that the Inspector General investigation was “incomplete” and “failed to address the whistleblower’s legitimate concern about access to care for mental health patients at Hines.”

Let me tell you what this means in real life. My constituent Army specialist Tom Young served twice in Iraq with the 10th Mountain Division. At Hines, he asked for help with his posttraumatic stress disorder (PTSD). Two times, Hines turned Tom away because he was “not suicidal.”

After a suicide attempt, Tom went back to Hines, and they did not have room for him. Tom laid down on the Metra tracks in Prospect Heights on July 20, 2015.

Two days after Tom killed himself, your own Office of Accountability Review said no additional investigation is required of Germaine’s complaints that were addressed by the Inspector General. The Chief of Staff agreed.

Another constituent of mine, Army veteran Michael Swan waited over a year to see a neurologist and a year to see an endocrinologist. Even worse, doctors gave him a clear colonoscopy report showing no polyps. He then went to a civilian doctor later, and the doctor found 130 polyps.

The VA is saying that Germaine is wrong about Hines wait times in the mental health department, yet the Office of Special Counsel has criticized the Inspector General, saying it was "willfully ignorant about the allegations."

Do you still stand by your Office of Accountability Review report on this matter?

Secretary McDONALD. First, I think it is important to say that any veteran suicide is unacceptable. We all take it deeply personally, all of us, myself, yourself, being veterans.

So that is one of the reasons we held the suicide prevention summit that we held in February, to see what more we can do, what more can all us do as a community in order to eliminate the possibility of any veteran committing a suicide.

It was March 8, just a couple days ago, where we put out a press release of the steps we are going to take in order to increase our suicide prevention program. It is incredibly important.

Relative to mental health at Hines, the average wait time is 4.3 days. If that differs from what Germaine thinks it is, I would love to talk with her again.

As I told you, we have our Office of Medical Inspector at Hines now, trying to reconcile the difference between the Inspector General reports and what the Office of Special Counsel found. Our Deputy Secretary is digging deeply into this. We will contact Germaine to get more information.

[The information follows: the requested information was not available at the time this publication went to print.]

Senator KIRK. Thank you.

Secretary McDONALD. Yes, sir.

VETERANS CRISIS LINE CONTRACTOR

Senator KIRK. Let me follow up with Dr. David Shulkin.

You were here last week and testified about the veterans' crisis line putting new people in charge. I wanted to get the name of the contractor who was handling that voicemail that dealt with my constituent. Do you have the name of that contractor?

Dr. SHULKIN. I do. Link2Health, with the number two, Link2Health.

Senator KIRK. Link2Health. Are they still working on the veterans' crisis line?

Dr. SHULKIN. Yes, they are a backup contractor.

Senator KIRK. And since they have messed up Tom's call, why are they still hired?

Dr. SHULKIN. Well, after the issue was discovered with the voicemails, we went back to them and we put in new stringent requirements as part of the contract, and they have been adhering to that. There is no voicemail being used today.

Senator KIRK. Good. Thank you.

Ms. Murkowski.

CHOICE PROGRAM IN ALASKA

Senator MURKOWSKI. Thank you, Chairman.

Secretary, I think this is the first time that we have seen one another since you visited us in Alaska. I appreciate your willingness

to be there in Wasilla at an open mike. I think you got it unfiltered from our veterans.

You had some time since that visit to kind of process not only what Alaska veterans have said, but obviously veterans around the country.

Dr. Shulkin was here before the subcommittee last week. We had an exchange back and forth about the failings of the Choice program in Alaska.

Kind of the short sum of it was that Alaska VA healthcare system had long been resistant to sending patients to community facilities. They viewed that a better alternative was to send a vet all the way down south to Seattle rather than just using the services there at the Fairbanks Memorial.

Your predecessor, Secretary Shinseki, worked with us. We really thought we were on the road to that model VA health system. Then the Phoenix incident comes around.

Now, our veterans are saying very clearly, very loudly, our VA health system in Alaska is a mess. I referred to it last week as chaotic.

Without exception—without exception—the veterans who are talking to me say we need to ditch Choice, we need to go back to what we had built where VA have identified community providers, wrote referrals, paid the bills. It was a system that worked.

So I am concerned with the various proposals out there that we are seeing that “consolidate community care.” We do not want to participate in a national consolidated program. Those are all the buzzwords that just do not work for us.

We need a program that is like what we had, which is custom-developed for the fact that we are noncontiguous; we are highly rural; we have a mismatch between demand for providers, which is very, very high, and the supply of providers, which is, unfortunately, terribly low; and because our medical community is really self-sustained within the State.

So we do not want to be part of this consolidated national program. It scares me to death.

Given what you heard in Alaska, given the conversations that we have with Dr. Shulkin, how can we do this? How can we draw outside the lines, because that is what we have to do with Alaska? That is what we have to do, I think you know—a way we can figure out this integrated system of VA health system that works for Alaska.

I do not expect you to have the full answer in 2 minutes, but we need to have a better understanding as to where we are.

Secretary McDONALD. Believe it or not, I do have an answer, because as we put this program together, consolidated care, this network of great providers, it is with the learnings from Alaska as part of it.

We need to have in that network the Alaska Native Health System. We need to return to all the things we had before Choice. The problem with Choice was it created—it was well-intentioned—

Senator MURKOWSKI. It was non-Choice.

Secretary McDONALD. It was non-Choice. It created a single entry point call to a third-party administrator where you had the veteran given a phone number. And I know that does not work. I

mean, I was in Alaska. I went up to Point Hope to watch how the Alaskan health system worked.

We need to get back to where we were in Alaska. This bill will do to that or we are not advocating it. So that certainly is our intention.

Senator MURKOWSKI. Well, okay. You are saying that this bill gets us there. I need to know that we are all in agreement as to where there is, because your words are good. I think you recognize it and you see. But again, part of the frustration that our veterans have right now is that they saw how we had corrected a system that had failed our vets for years.

We built it, and then it was disassembled literally in a matter of months. So what I need to hear from you is that you agree that where we were before Choice came on is where we can get back to, and that is the direction that you want to take a.

Secretary McDONALD. That is certainly the direction I want to take it, and I am going to make sure that is built into any bill, because I thought the Alaska system, and it worked. It was Choice. It did provide choice.

David, do you want to say anything?

Dr. SHULKIN. I think, very specifically, we want to bring back the customer service piece. The Alaska VA staff had a great relationship with Alaska providers, the Southcentral Foundation, as well as the Indian Health Service, and other Federal programs up there.

We also had a great relationship with our veterans, and we want that back.

Senator MURKOWSKI. You know that you do not have it now.

Dr. SHULKIN. No, we are working hard to repair all the damage that happened up there, and there has been a done a lot of damage. There is no question. Both the Secretary and I heard this personally when we were up there.

VA HEALTHCARE OPERATIONAL ISSUES IN ALASKA

Senator MURKOWSKI. Let me ask about that then, just with regard to the day-to-day operations, because I think this really goes a long way to improving that relationship, to rebuilding that credibility.

We are sitting with a situation where, once again, we do not have a permanent director. We have not had one since Susan Yeager left. I personally think it was a tragedy that we could not keep her. I do not think I have met the director of the Northwest network.

We are having a difficult time with provider attrition. We are still having serious issues with provider recruitment.

Again, it is not that we can't figure this out. The Alaska Native Health Care System has figured it out. They seem to be up to keeping folks. VA cannot keeping folks. I do not understand why.

On a month-to-month basis, we do not know how well or how poorly our community-based outpatient clinics (CBOCs) are operating. We have a revolving door of providers there. We have low morale. We have fear of retaliation.

So I hear what you are saying about what we have to do, but you have a whole series of strikes against you right now that are going

to make it hard to ensure that that veteran feels like, okay, we are back on the right track.

At a minimum, it seems to me that we have to have some kind of framework for measuring the performance of what is going on. I do not know on a month-to-month basis whether our local VA system is improving or whether it has just entirely collapsed.

So is that something that you are considering and trying to put in place as you are looking at the bigger picture of how we get back to where we once were?

Dr. SHULKIN. Senator, I do not think that we have the time to go into the very specifics now. I will say that your assessment of the local VA situation is probably somewhat different than mine. We do have a lot of metrics. We have an excellent acting director, Linda Boyle, there. I would love to have you spend some time with her.

Senator MURKOWSKI. I know Linda well.

Dr. SHULKIN. Right. We have a search going on. We will name a permanent director in the very near future.

I have been there. The care at the VA is truly excellent. We have statistics we will be glad to show you.

The problem is our reputation has been hurt incredibly, and you are hearing it from the veterans because the Choice program has not worked. That is what we are working very, very hard right now to repair with TriWest. They have been working very hard with us to do that.

But we need these legislative fixes to fix the program once and for all.

So we will reach out to your staff and sit down and review those statistics with you. We have a lot of data on Alaska.

Senator MURKOWSKI. Well, I appreciate the statistics. But I also know that when I am sitting on an airplane with a veteran, he is not talking statistics. He is talking about his care. He is talking about how he was treated. He is talking about what it meant for him to basically feel like there was no response.

So I appreciate statistics. I know that we have to be paying attention to that. But I need to make sure that we have providers that we can recruit and we can retain. I need to make sure that we have a level of responsiveness that is more than just scheduling an appointment. It is one thing to say, yes, I got an appointment. It is another thing to get the care that our veterans have clearly earned.

So know that we need to stay very closely engaged with this, and we certainly intend to do that.

Secretary McDONALD. Senator, I would like to send over our team working on this new bill and make sure that we are aligned, that this will include the Alaska Native Health System and all the needs that we were able to address with the previous system.

Senator MURKOWSKI. I would look forward to sitting down with your folks. I appreciate that.

Thank you, Mr. Chairman.

Senator KIRK. I would like to ask Secretary McDonald for you, when you come to Chicago, to meet with Germaine and the Hines staff. I would like you to commit to that.

Secretary McDONALD. I have not been to Hines yet. I would like to go.

ADDITIONAL COMMITTEE QUESTIONS

Senator KIRK. Thank you.

I think with that, we will thank our witnesses and thank my partner, Senator Tester.

The hearing record will remain open until the close of next week. Members may submit questions at any time they want, until that time.

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

QUESTIONS SUBMITTED TO HON. ROBERT A. McDONALD

QUESTIONS SUBMITTED BY SENATOR MITCH McCONNELL

Question. I am very concerned about the recent reports of dysfunction and wrongdoing at the Cincinnati VA Medical Center, particularly as a number of my constituents rely on this facility for medical care. I understand the former VISN 10 Director recently resigned and the former Director of the Cincinnati facility has been removed. Are either of these individuals receiving benefits or salaries? What steps is the VA undertaking to correct the failures of leadership at this facility to ensure veterans are receiving the quality care they were promised and deserve?

Answer. The previous Director of the Cincinnati VA Medical Center (VAMC), Linda D. Smith, retired December 2, 2014, and she receives retirement benefits commensurate with her service. John Gennaro became Director of the Cincinnati VAMC in July 2015, but he recently accepted an assignment to another facility as Director. Mr. Gennaro was not implicated in any allegation of wrong doing, and he currently receives a salary and benefits as appropriate to his new position. The current interim Director of the Cincinnati VAMC, Glenn Costie, is not implicated in any allegation of wrong doing.

The former Director of Veterans Integrated Service Network 10, Jack Hetrick, retired February 24, 2016, and receives retirement benefits commensurate with his service.

To ensure quality care for our Veterans through our leadership means sustainable accountability in them and our supervisors. We will recognize what is going well and provide coaching and re-training where improvements are necessary. We will train our leaders to lead and our employees to exceed expectations and if not take corrective action when it's warranted and supported by evidence.

Question. Please provide an updated timeline for the design and construction phases of the Louisville VAMC—and ultimately for the facility's completion. This project was announced in 2006, and Kentucky's veterans have had to wait for too long to begin receiving care at this new facility.

[CLERK'S NOTE: The Department was unable to submit a response to this question.]

Question. In June 2014, the VA Office of Inspector General (OIG) was directed to conduct investigations of more than 100 VA medical facilities regarding potential scheduling manipulation practices, including at Kentucky's Fort Knox and DuPont VA facilities. What is that status of the OIG investigations of these facilities, and when will they be completed? I would ask that you please share any available information with my office regarding the investigation findings at these Kentucky facilities.

Answer. VA's OIG Report on Kentucky facilities was released, and summaries are provided below. VA's OIG did not find evidence to substantiate the allegations.

Louisville KY-2014-2890-DS-53	No intentional manipulation substantiated. —Report Referral Date: June 4, 2015 —VA's Office of Accountability Review (OAR) reviewed the OIG Report and evidence but did not conduct an independent investigation. —Closeout Memorandum Date: August 13, 2015 VA's OIG completed an investigation regarding potential improper appointment scheduling and falsification of audit data at the Dupont VA Healthcare Center in Louisville, KY. The allegation specifically stated that a Supervisory Medical Support Assistant (MSA) altered a business office audit to change the clinic's monthly scheduling accuracy. The investigation found that MSAs at the Dupont VA Healthcare Center were scheduling patient appointments correctly, in accordance with Veterans Health Administration (VHA) policy; specifically, VHA Directive 2010-027. The Supervisory MSA in question admitted to changing the audit; however, the column revised was a result of misinterpretation between two supervisors and was found to have no impact on the scheduled patients' desired dates or appointment wait times.
Louisville KY-2014-2890-DS-56	No intentional manipulation substantiated. —Report Referral Date: June 22, 2015 —OAR reviewed the OIG Report and evidence but did not conduct an independent investigation. —Closeout Memorandum Date: July 24, 2015 VA's OIG concluded an allegation of manipulation of wait times in the Surgical Clinic was unfounded.

Question. As the VA continues with reform efforts to improve and expedite healthcare for our Nation's veterans, does the agency need any additional authority from Congress to remove bad actors from the VA?

Answer. On March 23, 2016, the Secretary of Veterans Affairs submitted a legislative proposal to Congress entitled, "Department of Veterans Affairs Accountability Enhancement Act." This legislation would provide VA with the authority it needs to recruit, compensate, appraise, and, when necessary, discipline career healthcare executives to ensure that VA can operate as a values-based, high performance organization.

Question. Mental health issues remain a significant concern for many veterans. Are there any additional resources or authorities that the VA needs from Congress in order to provide effective treatment and care to veterans with mental health issues?

Answer. With the current resources and authorities, VA continues to be the largest integrated healthcare system in the United States, with numerous reports validating the quality of mental healthcare services. This is the result of a long history of research, academic affiliations, and a deep commitment to training and recruitment. For example, *Psychiatric Services*, a peer-reviewed journal of the American Psychiatric Association, has published a report comparing the quality of mental healthcare provided by VA to Veterans with a comparable population in the private sector. According to the study, "in every case, VA performance was superior to that of the private sector by more than 30 percent. Compared with individuals in private plans, Veterans with schizophrenia or major depression were more than twice as likely to receive appropriate initial medication treatment, and Veterans with depression were more than twice as likely to receive appropriate long-term treatment."¹

Additional resources and authorities are needed from Congress in order to maintain this leadership and to provide effective treatment and care to Veterans with mental health problems. Among other priorities, VA needs to explore all potential resources for recruiting and retaining high caliber mental health providers, including the availability of education debt reduction programs (EDRP). Most recently, through the Clay Hunt Suicide Prevention for American Veterans Act, new EDRP efforts have focused on psychiatry, but no additional funding was provided. Further, such incentives need to be broadened to other clinical specialties in short supply including psychologists. Funding EDRPs is a partnership between VA Central Office and local VA healthcare facilities.

The delivery of effective mental health treatment and care is best managed within a predictable funding strategy matched to the evolving needs of Veterans. Legislative requirements without additional appropriations not only limit VA's ability to act upon new mandates but also limit VA's ability to focus on/implement solutions in response to other key priorities. The Clay Hunt Act, as an example, did not pro-

¹ *The Quality of Medication Treatment for Mental Disorders in the Department of Veterans Affairs and in Private-Sector Plans*, Katherine E. Watkins, Brad Smith, Ayse Akincigil, Melony E. Sorbero, Susan Paddock, Abigail Woodroffe, Cecilia Huang, Stephen Crystal, and Harold Alan Pincus *Psychiatric Services* 2016 67:4, 391-396.

vide additional appropriations while imposing multi-million dollar, multiyear obligations which could only be met by diverting funding from other important projects including suicide prevention projects.

VA recognizes that to be effective in reducing Veteran suicide, VA must continue to develop Federal and community strategic collaborations that reach deep into all Veteran communities. To support this effort, VA stood up the Office of Suicide Prevention. The VA Suicide Prevention Office will create new inter-agency and public-private collaborations in order to reach each of our Nation's 22 million Veterans.

VA recognizes Congress as an important partner in preventing suicides. This partnership will be supported by reoccurring congressional briefings on the Office of Suicide Prevention's plans of action. Congress' feedback as well as working with their local districts across the Nation will be crucial to this effort.

VA practitioners report that they value being able to employ the full spectrum of their clinical skills and using interventions that are evidence based while practicing in VA. This requires an on-going requirement to train staff on emerging practices and create teams of providers to allow everyone to work within the scope of their unique area of competence. Over recent years, the addition of Peer Specialists has brought an additional resource to the healthcare team, has helped to combat any stigma associated with asking for mental healthcare, and has provided the opportunity to reach Veterans and Servicemembers (for example, Active Duty members seeking care after Military Sexual Trauma) who may otherwise go untreated.

Ongoing training and education of VA mental health practitioners and Peer Specialists contributes to staff retention and helps to ensure that Veterans have access to state of the art mental healthcare.

Question. It has been brought to my attention that some VA healthcare facilities lack the capability to provide care that meets the specific medical needs of female veterans. With this in mind, what efforts is the VA taking to ensure that all of its healthcare facilities are fully equipped to provide care to female veterans? What plans are being made in this regard for the new Louisville VA Medical Center?

[CLERK'S NOTE: The Department was unable to submit a response to this question.]

Question. Many Kentucky veterans have expressed concerns that as the VA continues its efforts to reduce the agency's backlog of pending claims that there is now a growing backlog of claims appeals. What efforts is the VA taking to continue reducing the claims backlog while also ensuring that veterans' appeals are processed in a timely fashion? Does the VA need any additional authority from Congress to assist with the reduction in either of these backlogs?

Answer. The Veterans Benefits Administration (VBA) has reduced the number of disability compensation claims pending more than 125 days by 87 percent, from a peak of 611,000 in March 2013 to a historic low of 79,004 claims, as of March 31, 2016. VBA's process and enhanced technology improvements, such as the Veterans Benefits Management System (VBMS) and the National Work Queue (NWQ), continue to provide increased efficiencies in the electronic claims process. By modernizing to an electronic claims processing system, VBA has increased claim productivity per claims processor by 25 percent since 2011 and medical issue productivity by 82 percent per claims processor since 2009. To continue this progress in 2017, VBA will build on the success of its transformation initiatives to further streamline and modernize the claims process with enhanced automation through VBMS, electronic workload management through NWQ, centralized mail, and the Veterans Claims Intake Program, which aims to further streamline and modernize the claims process.

With VBA's completion of record-breaking numbers of disability rating claims in recent years, a concomitant increase in the volume of appeals resulted. While VBA continues to prioritize rating claims, it is also placing additional focus on appeals. VBA is grateful for the funding that allowed us to hire 100 appeals full-time equivalents (FTE) in fiscal year 2015 and 200 appeals FTEs in fiscal year 2016. As of February 2016, VBA has increased its appeals workforce from 1,195 employees to over 1,490 employees and allocated \$10 million in overtime funds to support the appellate workload. In addition, we are leveraging our technology initiatives in support of modernizing the appeals process. However, VA will not be able to provide Veterans with timely decisions on their appeals without legislative reform to streamline and modernize the current appeal system. In the President's budget for fiscal year 2017, VA requested resources to lower the pending inventory of appeals and proposed legislation to simplify the appeals process. VA is working closely with Veterans Service Organizations, other Veteran stakeholders, and Congressional staff to develop legislative proposals that would achieve our shared goal of timely and high quality appeal decisions.

Question. In the summer of 2016, the Army is scheduled to begin construction of a new medical facility to replace the Ireland Army Community Hospital (IACH) at Fort Knox, Kentucky. Does the VA have a plan to replace the Fort Knox VA facility currently located at IACH to ensure area veterans see no disruption in care currently provided at this facility?

Answer. This new VA Clinic is necessary as a result of the Army's plans to build a new healthcare facility to replace the existing Ireland Army Community Hospital (IRACH). Currently, VA occupies space, via a sharing agreement, within the existing IRACH. However, VA will be unable to co-locate services within the Army's new healthcare facility because DoD and VA are not allowed to share appropriated funds for joint facility projects. In order to continue to provide healthcare to Veterans, VA seeks to obtain a permit from the Army and then build a separate clinic adjacent to the new Army healthcare facility. VA contemplates that the VA Clinic will be physically connected to the new Army health facility, through a covered walkway or other structure, and offer primary care and mental health services to Veterans in the Fort Knox area.

Current law does not allow for detailed planning/design, construction, or leasing of shared medical facilities that are not specifically under the jurisdiction of the Secretary, or for appropriated funds to be transferred to, or retained from, DoD or other Federal agencies for use in joint capital projects with VA. VA has proposed legislation (described in VA's fiscal year 2016 and fiscal year 2017 budget submissions and developed in consultation with DoD) that would provide for the inherent authority to do more detailed planning and design, leasing, and construction of joint facilities in an integrated manner. However, such legislation has not been enacted. Accordingly, VA lacks the authority to permit capital investment for shared medical facilities.

Earlier this year, VA began negotiating a permit with the Army to provide VA with the necessary access to the Army's land for construction and occupancy. The permit is for four acres in order to accommodate the building footprint and necessary parking. The Army has taken the lead on drafting the permit. A design-build contract was awarded to the United States Army Corps of Engineers (USACOE) for the construction of the VA CBOC in September 2016. An Architectural-Engineer (A/E) firm is drafting the final request for proposal (RFP) to be completed by March 2017.

Question. Substance abuse disorders, particularly opioids, continue to be a challenge for many veterans. What steps are being taken by the VA to improve education, monitoring and treatment of addiction? Does the VA need any additional authority from Congress to better coordinate care for veterans with substance abuse issues?

Answer. Providing additional funding to expand recruitment incentives, such as loan repayment for psychiatrists and other mental health providers, would be helpful in attracting and retaining addiction treatment providers in what is currently a highly competitive market in many locations.

Currently, VA is engaged in multiple efforts to improve education, identification and monitoring for substance use disorder (SUD) in patients, including those Veterans with chronic pain. VA has been working to expand access to evidence-based pharmacological and psychosocial addiction treatment services. This includes national training initiatives in evidence-based psychotherapies, such as cognitive behavioral therapy for substance use, motivational interviewing, and motivational enhancement therapy, which have been shown to effectively treat substance use disorders. VA, in concert with the 2011 Institute of Medicine (IOM) Report, *Pain in America*, and the National Pain Strategy from the Department of Health and Human Services (HHS), published in 2016, has recognized that improved competency in pain treatment across our health systems will lead to less reliance on opioid therapy, less exposure to the potential harms of opioid therapy, and better patient outcomes. To support these goals, VA and the Department of Defense (DoD) have developed the Joint Pain Education Program for primary care providers, a 31 module, evidence-based, comprehensive pain management curriculum that includes training in the appropriate screening for SUD in Veterans with chronic pain, and training in the safe use of opioids, including SUD monitoring.

VA, as part of its Opioid Safety Initiative (OSI), has created multiple tools and processes to help clinicians identify SUD in Veterans being treated for chronic pain before and during treatment with opioid analgesics, to monitor their clinical outcomes, and ensure referral to appropriate treatment to reduce risk of activating SUD, or to manage SUD when it is co-morbid with chronic pain. Such tools and procedures include:

- The Opioid Therapy Risk Report (OTRR), which provides detailed metrics on all the risks and strategies for managing risk for Veterans prescribed long-term opioid therapy for pain. The OTRR metrics are available in the clinic on the electronic medical record to support providers' efforts to monitor and manage risks when caring for patients with chronic pain who are prescribed long-term opioids.
- VA developed predictive model-based clinician decision support tools which are available nationally. The Stratification Tool for Opioid Risk Mitigation tracks patients receiving opioid analgesics or with opioid use disorders, estimates risk of overdose or other adverse events, flags prior non-fatal overdose and suicide-related events, identifies personal risk factors, and suggests and tracks use of patient-tailored risk mitigation strategies and non-pharmacological pain treatments. Suggestions include a variety of guideline recommended strategies, including avoidance of high dose prescribing and risky medication combinations; timely follow-up; medication reconciliation; side-effect management; screening for substance use; ensuring mental health assessment and addiction treatment when needed; and use of physical therapy, Integrative Health, and behavioral therapies. It additionally provides information about patients' care providers and appointments to facilitate care coordination. The tool can be used to improve the safety of care for individual patients, or on a population level to facilitate systematic application of specific risk mitigation strategies to patients with the greatest risk of overdose or suicide-related events.

The OSI Toolkit, developed and maintained by an interdisciplinary expert pain task force provides evidence-based guidance and trainings to help clinicians manage pain and opioids safely, including clinical guidance on safe medication tapering.

Additionally, VA has been working to expand access to medication-assisted treatment (MAT) for opioid use disorders since fiscal year 2000. VA efforts have included specific funding for hiring Addiction Medicine specialists to expand MAT access in under-served areas, clinical mentorship programs to support newly trained buprenorphine prescribers, a technical assistance program consisting of monthly webinars and email consultation, and on-going management monitoring, attention, and action planning regarding meeting needs for MAT services. As a result, VA has substantially expanded access to MAT from just under 12,000 patients (27 percent of those diagnosed with opioid use disorders (OUD)) in fiscal year 2010 to over 20,000 patients (30 percent of those diagnosed with OUD) in fiscal year 2015. In the fourth quarter of fiscal year 2015, 35.4 percent of OUD patients received MAT (methadone, buprenorphine or injectable naltrexone). Prioritization of expansion of MAT services is encouraged by inclusion of MAT access measures on leadership performance plans and as part of VA's Psychotropic Drug Safety Initiative. VA continues to work to expand MAT access in locations with lower capacity or barriers to access to services (e.g. rurality), including through innovative models such as group practice visits and telemental health models.

The Ryan Haight Online Pharmacy Consumer Protection Act generally requires that VA telehealth providers must have at least one in-person medical evaluation prior to prescribing controlled substances via telemedicine.

This can be a problem when VA telehealth providers are not located close to the Veteran or when the Veteran's provider retires and another provider needs to begin furnishing care to the patient. We believe that the Drug Enforcement Administration could assist VA with this issue through the regulatory process; however, Congress could also assist by granting VA telehealth providers special authority to prescribe controlled substances without having conducted a prior in-person medical evaluation.

We note that on July 22, 2016, the President signed into law the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198), which authorizes a range of measures intended to combat opioid addiction and overdoses. We are working to implement the provisions of this law affecting VA. For example, the law requires all practitioners (including VA) to certify certain information when registering to prescribe controlled substances; VA must establish guidance that each provider must use the Opioid Therapy Risk Report tool before initiating opioid therapy to treat a patient; VA must require all employees responsible for prescribing opioids to receive education and training on pain management and safe prescribing practices; and Each VA medical facility director must identify and designate a pain management team of healthcare professionals. We will alert the Committees if we identify any legislative changes that are needed as a result of these new authorities.

QUESTIONS SUBMITTED BY SENATOR SUSAN M. COLLINS

DYSFUNCTIONAL CONTINUUM OF CARE—CHOICE PROGRAM

Question. I have heard from veterans, veteran services organizations, and VA officials that the Choice Program's continuum of care process is broken and dysfunctional.

Last month, the entire Maine congressional delegation sent you a letter regarding the VA's incredibly flawed administration of the Choice Program in our State. According to the Department's own data, fewer than 50 percent of eligible Choice Program patients in Maine have received the appointments they need and have requested. The contractor chosen by the VA, Heath Net, has performed poorly. The process to correct many of the issues with Choice may take years. In the meantime, there are veterans in rural communities waiting to receive access to desperately needed care.

Can you provide an assurance regarding when these veterans can expect to receive the appointments they need?

Answer. VA is continuing to examine how VCP interacts with other VA health programs, including the delivery of direct care. In addition, VA is evaluating how it will adapt to a rapidly changing healthcare environment and how it will interact with other health providers and insurers. VA anticipates improving the delivery of community care through incremental improvements as outlined in the October 30, 2015, Plan to Consolidate Community Care Programs, building on certain provisions of the existing VCP. Implementation of these improvements requires balancing care provided at VA facilities and in the community, and addressing increasing healthcare costs. VA is committed to improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs.

Relevant to Maine Veterans, the ARCH program expired on August 7, 2016. Veterans who participated in the ARCH program will continue to receive care under VCP and will be eligible for same services that ARCH offered. Veterans who did not previously participate in the ARCH must meet the Choice eligibility criteria (living 40 miles away from a VA facility with a full time primary care physician or a VA facility is not able to provide needed care within the wait time goals of the Department (30 days)). VCP should work to expand the availability of hospital care and medical services for eligible Veterans. We continue to work with our VCP contractor in Maine, HealthNet, to recruit more eligible VCP providers to improve VCP and help us ensure that all Veterans in Maine have access to care. VA has also begun using VCP Provider Agreements in Maine to improve our ability to get our Veterans timely appointments with eligible community care providers.

Effective care coordination is critical to enabling a Veteran-centric care experience and supporting positive health outcomes through clear continuity of care and appropriate care and disease management. Under VA's "Plan to Consolidate Community Care Programs," VA would define a clear process for transfer of medical documentation between VA and community providers when Veterans are referred into the community. VA would also establish objectives, roles, and processes for care coordination to enable a smooth Veteran experience across VA and community providers. The care coordination process would be centered on Veterans' relationships with their PCP. The PCP and supporting coordinator staff, whether at a VA facility or in the community, would assist Veterans with basic care coordination and patient navigation regarding scheduling appointments and seeking appropriate follow-up care. Veterans receiving care from community PCPs that do not have the capacity or capability to provide required coordination would be able to rely on VA for those services. For Veterans requiring more robust care coordination, regardless of whether they see a VA or community PCP, VA would provide programs for care and disease management and case management, as appropriate. This model would integrate with and utilize established and evolving care coordination models at VA, such as the Patient Aligned.

VA PARTICIPATION IN PRESCRIPTION DRUG MONITORING PROGRAM

Question. Prescription opioid and heroin abuse has reached epidemic proportions in our communities. A recent study estimated that nearly one million veterans are taking prescription opioids and more than half use them "chronically" or beyond 90 days. Although these prescriptions may be necessary to a patient's care, another study noted that the risk of death by accidental overdose among patients at Veterans Administration facilities is nearly twice that of the non-veteran population.

Prescription drug monitoring programs, or "PDMPs," are one of the most important tools available to confront and prevent prescription opioid abuse. These State

systems can give doctors crucial information about a patient's prescription drug history, particularly when patients are receiving care both inside and outside of the VA system. VA healthcare providers have the authority to share information with State PDMPs, but they are not required to do so, and participation varies widely across the country. For example, in Maine the VA Health Care System reports to and queries the State PDMP, but this was a long time coming and is not the practice in all States.

Has the VA considered establishing standards for PDMP use among prescribers and pharmacies in the VA system?

Answer. Prescription opioid and heroin abuse has reached epidemic proportions in our communities. A recent study estimated that nearly one million veterans are taking prescription opioids and more than half use them "chronically" or beyond 90 days. Although these prescriptions may be necessary to a patient's care, another study noted that the risk of death by accidental overdose among patients at Veterans Administration facilities is nearly twice that of the non-veteran population.

Prescription drug monitoring programs, or "PDMPs," are one of the most important tools available to confront and prevent prescription opioid abuse. These State systems can give doctors crucial information about a patient's prescription drug history, particularly when patients are receiving care both inside and outside of the VA system. VA healthcare providers have the authority to share information with State PDMPs, but they are not required to do so, and participation varies widely across the country. For example, in Maine the VA Health Care System reports to and queries the State PDMP, but this was a long time coming and is not the practice in all States.

Question. Has the VA considered establishing standards for PDMP use among prescribers and pharmacies in the VA system?

Answer. The Veterans Health Administration (VHA) is developing a policy, VHA Directive, *Querying State Prescription Drug Monitoring Programs*, which will govern the querying of State PDMPs by VA providers. The policy will establish a minimum standard for querying PDMPs and ensure compliance with applicable Federal and State laws. It is anticipated that this policy will be published in mid-fiscal year 2017.

In addition, VA's Virtual Lifetime Electronic Record Health program continues to actively partner with the eHealth Exchange to encourage PDMPs to move towards the use of national standards for the exchange of opioid prescription information. As PDMPs adopt these national standards, it will enable a bi-directional exchange of information, improving access by VA and non-VA clinicians nationwide to prescription history for their patients in order to make the most appropriate and safe treatment decisions.

QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

USE OF SOCIAL SECURITY NUMBERS AS IDENTIFIERS FOR VETERANS

Question. Mr. Secretary, I would like to see VA discontinue using social security numbers to identify individuals in all VA information systems. Until that is done, veterans will be at risk for identity theft and fraud. What are your thoughts on this proposition? Is the VA currently working to discontinue the use of social security numbers to identify individuals? If not, why not? If the absence of a single data backbone at VA is a barrier to achieving the discontinuation of social security numbers, please provide a status update on the Department's efforts to create a single data backbone and what additional resources are needed to fully bring it online.

Answer. VA's primary uses of Social Security Numbers (SSNs) are to: (1) locate Veterans and their dependents to ensure correct identification associated with the delivery of benefits and services, and (2) identify employees for employment-related record keeping. As mistaken identity in the delivery of healthcare can result in catastrophic and tragic outcomes, VA must ensure 100 percent accuracy in patient identification. Until such time when a comprehensive and equally accurate means to do this is established and implemented, the use of SSNs remains the single best means of ensuring patient identification. In addition, SSNs must be used if required by law or regulation, for purposes such as:

- Background investigations;
- Security checks for validation purposes, such as computer matching of records between government agencies; and
- Support of unique identification.

VA currently relies on the SSN to ensure that the correct records are obtained and utilized to determine eligibility for VA benefits such as compensation, disability,

education, and rehabilitation. VA is required by law (38 U.S.C. 5103A) to request evidence from third parties on behalf of Veterans to support their claims. In these requests for evidence, VA must sufficiently identify the party for whom it is seeking information. Many entities holding Veterans' records, including the Department of Defense (DoD), other government agencies, and private parties, continue to utilize SSNs as a primary identifier. As such, VA will face substantial challenges in obtaining records from these entities on behalf of Veterans if precluded from identifying Veterans by their SSNs. This will negatively impact Veterans by delaying the time required to process their claims and possibly even preventing VA from obtaining the records needed to establish Veterans' eligibility to benefits.

VA's success rate in matching records with other Federal and non-Federal organizations is over 85 percent when the SSN is available compared to 20 percent when the SSN is not used. VA providers will not have access to important outside care information and could order redundant tests, slow decisionmaking, or make incorrect and even harmful decisions when such data is unavailable. VA also participates in Health Information Exchanges with DoD, Walgreens, Kaiser Permanente, etc., and without the use of the SSN to positively identify the Veteran, critical health information will not be available leading to poor healthcare decisions and slower treatment.

Elimination of SSN use is not solely a function of information technology (IT). The business processes used by the Veterans Health Administration (VHA), Veterans Benefits Administration, and other VA offices require a complete overhaul in how they establish absolute identity verification inside VA and most importantly outside of VA. IT solutions to eliminate SSN use can only occur after the integrated and comprehensive review of the prevalence and inter-connectedness of SSN use is complete.

SSN Reduction Effort

VA recognizes the growing threat posed by identity theft and the impact on Veterans, dependents and employees. In 2009, VA created and implemented the enterprise-wide Social Security Number Reduction (SSNR) effort, in response to the Office of Management and Budget Memorandum 07-16, "Safeguarding Against and Responding to the Breach of Personally Identifiable Information (May 2007). The key goal of the SSNR is to reduce or eliminate the unnecessary collection and use of SSNs as the Department's primary identifier, while maintaining the 100 percent requirement for proper Veteran-Patient identification. For example:

- VHA eliminated the use of SSNs on appointment letter correspondence and the Veterans Health Identification card.
- VBA is currently evaluating the elimination of SSNs from correspondence.
- The National Cemetery Administration has reviewed and reevaluated all of its forms requiring SSNs.
- VA/DoD health information exchange Joint Legacy Viewer is using the Integration Control Number (ICN), Electronic Data Interchange Personal Identifier and other demographics for trait matching while phasing out use of the SSN.
- VHA is utilizing a SSNR tool to collect VHA's SSN holdings data but it has limitations due to outdated technology. The Office of Information & Technology (OIT) is currently developing a new SSNR tool for VA wide use which is expected to be completed by September 2017.

Master Veteran Index System

As VA works to migrate away from the use of SSNs as the sole means of Veteran identification, OIT is collaborating with the Veterans Relationship Management Initiative to create the Master Veteran Index (MVI) system and require MVI integration for every VA system. MVI serves as the authoritative identity service within VA. MVI assigns an ICN, a unique identifier, for each Veteran. The ICN is a sequentially assigned, non-intelligent number that, in itself, does not provide any protected sensitive information about the Veteran-patient. The ICN is a means to accurately and securely track the individual and confirm their identification. ICNs conform to the American Society for Testing and Materials International standard for a universal healthcare identifier. MVI now has information on over 26 million Veterans and beneficiaries who have applied for healthcare. While additional work remains to fully extricate SSNs from Veteran identification, including re-engineered business processes and legacy system upgrades, programs like MVI have made significant progress towards the goal of SSN reduction.

Conclusion

VA has made considerable progress in implementing the SSN reduction initiative since the Office of Management and Budget's mandate in 2007. VA continues ongoing activities to either eliminate or reduce the use of SSN's with the goal to replace

the SSN with an alternative primary identifier. The timeframe to implement an alternate primary identifier would be contingent upon laws, business needs, technology upgrades, and funding.

DISPOSITION OF FINAL REPORTS ON TOMAH

Question. Mr. Secretary, I want to emphasize to you my belief that the Office of Accountability Review's investigation of accusations of widespread retaliation against whistleblowers and the culture of fear at the Tomah VA Medical Center must be made publically available so that veterans, VA employees and the American public are assured that the Department has uncovered and addressed the troubling events at the Tomah VA and related issues nationwide. The same goes for the outside clinical review, which is being done in follow-up to the Agency's initial review of the incidents at Tomah.

I have previously discussed this issue with other members of the VA leadership team. I want to reiterate its importance to you as I did with the Deputy yesterday.

When will VA make public its findings on these matters? I would like to know the timeline of VA's plan for transparency on:

—The OAR investigation of accusations of widespread retaliation against whistleblowers and the culture of fear at the Tomah VAMC and

—The outside clinical review.

Answer. As of June 10, 2016, litigation is pending for one of the subjects of the Administrative Investigation Board (AIB). Consequently, we are currently unable to release the AIB Report.

CHOICE PROGRAM

Question. Mr. Secretary, in early February, I wrote to VA expressing my frustration with the Choice Program. Recently, there has been an alarming increase in the number of complaints from my constituents about their interactions with HealthNet, the 3rd Party Administrator for the area in which my constituents receive their healthcare services. For example, a veteran recently shared with me that after months of delay at VA, he was referred to the Choice Program and scheduled for surgery at a non-VA hospital. When he called to confirm the surgery with the hospital, it had no record of him or a surgery being scheduled for him. A month later he received the surgery at a different hospital. It is not uncommon for a veteran to call me after spending many frustrating hours on the phone trying to get an appointment scheduled.

What is the Department doing to address these problems and improve the administration of and veteran experience with Choice?

Answer. The purpose of the Veterans Choice Program (VCP) was to improve access to care for Veterans by allowing them to seek care in the community if they were eligible based on certain criteria specified in statute.

Since the implementation of VCP on November 5, 2014, a number of amendments to the law and to VA's regulations have further expanded the number of Veterans eligible for VCP.

VA recognizes there have been and continue to be challenges implementing VCP. We are identifying those challenges, implementing immediate fixes where we can, and building long-term solutions, as needed. VA's overarching plan for community care is to consolidate programs and simplify eligibility criteria and processes. VA is continuing to examine how VCP interacts with other VA health programs, including the delivery of direct care. In addition, VA is evaluating how it will adapt to a rapidly changing healthcare environment and how it will interact with other health providers and insurers. VA anticipates improving the delivery of community care through incremental improvements as outlined in the October 30, 2015, Plan to Consolidate Community Care Programs, building on certain provisions of the existing VCP. Implementation of these improvements requires balancing care provided at VA facilities and in the community, and addressing increasing healthcare costs. VA is committed to improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs. While VA can implement some of the provisions from the Plan within the constraints of the current budget, there are certain provisions that require legislation. The Plan identified key legislative changes needed to consolidate the community care programs and standardize Veteran eligibility for community care. While some legislation has been proposed, none has been passed into law as of October 2016. Without the legislation identified in the Plan, full consolidation cannot be achieved.

Among other improvements, the Veterans Health Administration (VHA) simplified the scheduling procedures and published a Deputy Under Secretary for Health for Operations and Management memorandum on June 9, 2015, which revised proce-

dures to require providers to write a return-to-clinic order and schedulers to enter the date contained in that order as the clinically indicated date (CID). This new process keeps future appointment decisionmaking with the provider and patient, rather than the scheduler. Associated training was provided to schedulers at that time. Additionally, VHA uses the “scheduling trigger tool” database to identify and notify facility leadership of scheduling irregularities. Of note, a root cause of scheduling errors is the highly manual, 30-year old scheduling software. VistA Scheduling Enhancement (VSE) has been deployed to about 30 clinics at 5 sites and is planned for national deployment starting in February 2017. VHA anticipates this new scheduling software will reduce the number of scheduling errors.

Several initiatives are planned for VHA’s “Summer of Scheduling,” including:

- National Rollout of VSE:* The rollout of VSE will be achieved through a train the trainer or “Super User” approach, developing local experts to train others. The rollout began in May 2016 and is planned for national deployment starting in February 2017, with ongoing associated training.
- Hire Right, Hire Fast:* This project’s goal is to ensure that every facility has the right number of Medical Support Assistants (MSA), with the right skills, who can provide the right experience for Veterans.
- Own the Moment:* VA knows that every interaction between an employee and a Veteran matters. This project reinforces the importance of serving with a focus on principles and values, empowering VA employees to pursue what’s right for the Veteran when procedures serve to limit services.
- Standardized MSA Onboarding/Training:* New MSA onboarding would include a two-week training program that draws its curriculum from scheduling rules for technical training, customer experience training, and medical center policies. The onboarding will provide a mentor for all new MSAs and use the VSE “Super Users” model. Deployment will follow the national rollout of VSE.

VA GRADUATE MEDICAL EDUCATION (GME) EXPANSION AND STAFFING

Question. The 2014 VA reform law was a comprehensive response to system-wide barriers to veterans’ access to care. The law’s Choice Program is an important step to remove those barriers through non-VA care, but it is no substitute for increasing the internal provider capacity of the VA. The VA reform law included a provision I authored to increase by 1,500 over 5 years the number of graduate medical education residency positions. Can you please provide me an update on VA’s plans for ensuring that the goal of 1,500 positions is met?

I note in your testimony that in fiscal year 2015, VHA hired 41,113 employees, for a net increase of 13,940 healthcare staff. What did you do to bring all those people on board? Can you also please briefly discuss the Department’s efforts to attract qualified physicians to VA to care for our veterans? I know that in Tomah, VA increased the pay available for hard-to-fill positions.

Answer. To help reach the goal of up to 1,500 new residency positions, VA is conducting outreach and providing consultative services, and strategic and targeted funding to assist VA facilities and academic affiliates when addressing the complex and time intensive process of GME residency expansion. VHA has authorized more than 372 new GME positions during the first 2 years of the 5 year program. In addition:

- The accreditation process for each new GME residency program can take up to 3 years and is managed by our affiliated partners (the program sponsors).
- Once a program is accredited, incremental expansion to full capacity takes 3 to 4 additional years.
- Since VA residency positions are rotational and complementary to other clinical experiences, each full-time VA position is occupied by three to four unique medical residents; thus, the affiliated academic program sponsor must secure additional support for the remaining portion of the residency training outside of VA, and this support may be limited by existing Medicare program “caps.”

VA encourages all stakeholders, including Members of Congress working with community stakeholders, to use this unique opportunity to help Veterans improve access to care by identifying potential new affiliates, while VA facilities expand their existing VA GME programs or create new ones.

FEMALE VETERANS

Question. Your request includes \$372 million for Minor Construction and would provide funding for ongoing projects that renovate, expand and improve VA facilities, while increasing access for our veterans. My understanding is one emphasis for this funding will be projects that enhance women’s health programs. Can you please describe these projects?

I met with several veterans groups recently who were concerned with the lack of women healthcare professionals at VA. I support hiring more female healthcare professionals for the growing population of women veterans using VA primary care and mental healthcare clinics. Many women prefer receiving healthcare services from female providers. My understanding is that since 2003, women veterans' healthcare usage at VA facilities has increased by more than 100 percent. What is the Department doing to bring more female healthcare professionals to VA?

Answer. Approximately 98 percent of Women's Health providers are women. VHA's NRP is available to provide recruitment support for Women's Health providers (Primary Care and Obstetrics/Gynecology). Also, there is no longer a prohibition on specifically targeting female PCPs to consider women's health careers in VHA through recruitment marketing/advertising.

In addition to hiring, VHA is focused on training to enhance skills of its workforce to provide care for women Veterans. VHA has provided training to nearly 2500 primary and emergency room providers through a 2½-day intensive review of gender specific women's healthcare that includes training hands-on training for breast and pelvic examination. The majority of providers trained are women. One hundred percent of Medical Centers and 90 percent of Community Based Outpatient Centers have Designated Women's Health Providers.

VA provides a full range of services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. VA has focused on improvement of its facilities to meet the needs of the growing numbers of women Veterans we serve.

In order to review facilities in terms of accommodations for women Veterans, including required privacy and security, VHA has adopted Environment of Care (EoC) standards. These standards are now incorporated into a tablet-based EoC survey that is conducted monthly. The Women Veteran Program Manager is a member of the team conducting this survey monthly. All deficiencies detected must have a remediation plan attached, and the correction of these is tracked electronically. The EoC data is rolled up to the facility and the Veterans Integrated Services Network (VISN) monthly, and is the responsibility of the VISN Capital Asset Manager.

When there is a need for remodeling or construction to enhance the facilities, the VISN submits plans through the Strategic Capital Investment Planning (SCIP) process. The SCIP Board reviews and prioritizes the requests, and projects that include the needs of women Veterans are given additional points in the prioritization. The VHA Office of Women's Health Services subject matter expert support for reviews related to women's needs within the SCIP process. This allows for input on the specific facility needs for accommodations for women Veterans.

VA is proud of high quality healthcare for women Veterans. VA is on the forefront of information technology for women's health and is redesigning its electronic medical record to track breast and reproductive healthcare. Many women Veterans entering the VA system are of child-bearing age. VA provides full gynecological care, including maternity care, and 7 days of newborn care for all women Veterans either on-site or through Care in the Community, paid VA. VA is implementing a policy that requires maternity care coordinators at all VA medical centers that stay in contact with women during their pregnancies to support and coordinate their care.

Quality measures show that women Veterans using VA healthcare are more likely to receive breast cancer and cervical cancer screening than women in private sector healthcare. VA also tracks quality of care by gender and, unlike other healthcare systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management. Some of our national accomplishments include the following:

- VA completed two mobile applications for Women's Health, Caring for Women Veterans and Pre-Conception Care, that are available for providers in the community to download when caring for women Veteran patients.
- Maternity Care Coordination Telephone Care Program provided care coordination services to over 2000 unique pregnant Veterans, over 20 percent of whom resided in rural zip codes.
- Breast Care Registry to enhance care coordination of breast cancer screening and treatment for women Veterans.
- Women Veterans Call Center (WVCC), created to contact women Veterans to inform them about eligible services. As of February 2016, WVCC received 30,399 incoming calls and made 522,038 outbound calls, successfully reaching 278,238 women Veterans.
- An enhanced provision of care to women Veterans by focusing on the goal of developing Designated Women's Health Providers (DWHP) at every site where women access VA. One hundred percent of VA medical centers and 90 percent of VA community based outpatient clinics have DWHPs

- The training of nearly 2,500 providers in women’s health and continued training of additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a DWHP.
- Pursuant to Veterans Access, Choice, and Accountability Act, expanding the eligibility for Veterans in need of mental healthcare due to military sexual trauma (MST) experiences of sexual assault or sexual harassment that occurred during their military service. All MST-related healthcare is provided without copayment requirements.

VA is enhancing facilities, training healthcare staff, and improving access to services to meet the current and future healthcare needs of women Veterans.

EXEMPTING COPAYMENT REQUIREMENTS FOR NALOXONE RESCUE KITS AND EDUCATION

Question. Please explain why the Department believes it is so critical to veteran patient safety to eliminate copayments for naloxone kits and related education.

Answer. Patients who are told by their medical providers that they are at high-risk for drug overdose often still do not believe that overdose will happen to them. During efforts to implement the Overdose Education and Naloxone Kit program nationally in VA, numerous healthcare providers have reported that patients who are considered at high-risk for drug overdose have refused the naloxone kits because they do not believe they will need it and therefore, they are unwilling to pay the co-pay for the medication. We greatly appreciate Congress’ enactment of provisions eliminating copayment requirements for medication and education and counseling for opioid antagonists in section 915 of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114–198), and we are working to implement these changes as quickly as possible.

SUBCOMMITTEE RECESS

Senator KIRK. The next meeting of the subcommittee will be on Thursday, April 7.

We will stand adjourned. Thank you, Mr. Secretary.

[Whereupon, at 12:20 p.m., Thursday, March 10, the subcommittee was recessed, to reconvene Thursday, April 7, at a time subject to the call of the Chair.]