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

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

ON

H.R. 4974/S. 2806

MAKING APPROPRIATIONS FOR MILITARY CONSTRUCTION, THE DEPARTMENT OF VETERANS AFFAIRS, AND RELATED AGENCIES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2017, AND FOR OTHER PURPOSES

Department of Defense

Office of the Secretary of Defense
Department of the Air Force
Department of the Army
Department of the Navy

Department of Veterans Affairs

Veterans Benefits Administration
Veterans Health Administration

Government Accountability Office

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

THURSDAY, MARCH 3, 2016

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

The subcommittee met at 10:55 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Mark Kirk (chairman) presiding.

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

DEPARTMENT OF VETERANS AFFAIRS

VETERANS HEALTH ADMINISTRATION

STATEMENT OF HON. DAVID J. SHULKIN, MD, UNDER SECRETARY FOR HEALTH

ACCOMPANIED BY MARK YOW, CHIEF FINANCIAL OFFICER

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. The subcommittee is holding a hearing today to review the 2017 budget request. The President's request is for $78 billion for funding the Department of Veterans Affairs (VA), an increase of 4.9 percent. About $68 billion of that, 87 percent, is for veterans' medical care.

This subcommittee and this Congress have given all of the funding that you have requested and more. The answer to every VA problem is not just more money and not just give us flexibility. We need to talk about the VA's culture of corruption with results and talk about performance. We need to talk about accountability and putting veterans first, not bureaucrats.

First, a few housekeeping items. We will follow the early bird rule, alternating sides, majority and minority, to defer opening statements, and do 5-minute rounds of questions. And we will do a second round if needed.

Let me now recognize my friend, the man representing the entire Big Sandy metroplex in Montana.

STATEMENT OF SENATOR JON TESTER

Senator TESTER. Thank you, Mr. Chairman, and a metroplex it is. I want to thank all of you for being here today in front of the appropriations subcommittee, VA military construction (MILCON), and I want to thank you for your service to this country's veterans.

You have difficult jobs, and I appreciate the work that you do. In many ways, both the Veterans Health Administration (VHA) and the Veterans Benefit Administration (VBA) have made some significant progress over the past year, but I am sure that you would agree that we have much more work to do.

The intent of the Choice Act was to give veterans more opportunity to seek timely care in their communities, but as we all know, in practice it simply has not happened. Some of the fault lies with the VA. Some of the fault lies with us in Congress. And at least in my opinion, much of that fault, which we have to bear the responsibility for, bears with a third-party administrator, at least it does in the State of Montana.

Veterans in places like Butte continue to be frustrated by the time and hassle it takes to schedule appointments through Choice, and that is directly related to the third-party administrator. Community providers in places like Billings continue to be frustrated by the time it takes to get authorization and reimbursement for care. As a result, the largest healthcare provider in my State of Montana will not participate in Choice, and that is because of that third-party administrator.

VA employees continue to be frustrated because they have to go through a middleman, the third-party administrator, to connect veterans with the care that they need. And I have heard these frustrations directly from Montanans, and their frustration, along with mine, is not getting less. It is getting greater each day.

Dr. Shulkin, we have had conversations about this. They are the same conversations that I have had with Secretary McDonald multiple times over the past weeks. Yes, fixing the VA, making sure that we provide the benefits to our veterans does require some resources, and that is what we are here today to discuss, your budget.

But it also requires using all the tools that are available to you in a more effective way. If you do not have the tools that you need, we need to know about it because if you are not effectively using the tools you have because of a problem we have created, we need to fix it. Today I want to hear more about the budgetary needs of the VA, but I also want to hear about how the VA is going to make more effective use of the tools that you already have at your disposal.

Again, I want to thank all of you for being here today. I look forward to this discussion. And, Mr. Chairman, I appreciate your work on this subcommittee. Thank you.

Senator KIRK. I would like to welcome our witnesses. David Shulkin is the Under Secretary for Health. Mr. Shulkin—Dr. Shulkin—I will give you a chance for first testimony, and we welcome you now.

SUMMARY STATEMENT OF HON. DR. DAVID J. SHULKIN

Dr. SHULKIN. Thank you. Good morning, Chairman Kirk, Ranking Member Tester. Thank you for this opportunity to appear before you to discuss the Veterans Health Administration's fiscal year 2017 and 2018 medical care appropriations budget request. I am accompanied today to my right by Mark Yow, who is our Chief Financial Officer.

Last year in 2015 it was a very big year for addressing some of the critical issues that we have before us in VHA. The Department is working hard to rebuild trust with veterans and the American people, improving service delivery, setting the long-term course for VA excellence and reform, while delivering better access to care and benefits. This includes the Department's MyVA initiative, which reorients VA around the veterans' needs and empowers employees to assist them in developing excellent customer service to improve the veteran experience.

As we enter into 2016, all of us in the VA healthcare system will be focused on the MyVA initiative, as well as VHA's Blueprint for Excellence. The Blueprint is aligned with the Department's strategic plan and supports the MyVA initiative. The Blueprint for Excellence will serve as a guide in all of the programs I mentioned in my written testimony. I am confident that the deep sense of mission we carry through the next year and any challenges that we may face will be addressed by this.

VHA's 2017 budget request will support VA's goals to expand access to timely, high-quality healthcare, and to continue to transform the Department through its MyVA initiatives. Through the fiscal year 2017 budget, we will continue to develop and expand our mental healthcare system with the goal to reduce veteran suicides. We are committed to increasing access to care for veterans and focus our efforts on addressing veterans who have the most significant health needs first.

We have placed a special emphasis on telehealth services for those in rural and remote locations, and for areas that have a shortage of specific healthcare professionals, such as psychiatrists. This past weekend, in fact, VHA held its second system-wide access stand down where every medical center across the country this past Saturday was working hard to reduce the wait times for veterans who were waiting for care.

To address the growing number of women veterans, VA is strategically enhancing the services and access for female veterans. Another high priority is ensuring that all enrolled veterans who require treatment for hepatitis C have access to the necessary therapies. VA is also dedicated to promoting the health and well-being of Caregivers. It is important to know that this budget allows us to continue our commitment to innovative and cutting-edge medical research that is focused on improving veteran health outcomes.

I want to highlight our Million Veteran Program and research in precision medicine that will allow VA to remain a leader in advancing discoveries to improve healthcare for all Americans.

The cost of fulfilling this care and other obligations to our veterans grows, and we expect it will continue to grow for the foreseeable future. We know that services and benefits for veterans do not peak until roughly 4 decades after a conflict ends. Therefore, more resources will be required to ensure that VA can provide timely, high-quality healthcare into the future.

We know that we have much work to do in fixing access issues for veterans, and filling our critical leadership and healthcare professional openings, and ensuring our new Veterans Choice Plan works better for veterans than it has over the past year. I came to VA approximately 8 months ago from the private sector to fix

these problems, and I am building a leadership team that is now committed to doing this and implementing sustainable change. The fiscal year 2017 budget requests additional resources which are critical to providing veterans the care they have earned through their service and sacrifice.

In conclusion, I appreciate the hard work and dedication of VA employees, our partners from veteran service organizations who are important advocates for veterans, our community stakeholders, and our dedicated VA volunteers. I respect the important role that Congress has in ensuring veterans receive quality healthcare and benefits that they rightly deserve. I look forward to continuing our strong collaboration and partnership with the subcommittee, and other committees of jurisdiction, and the entire Congress as we work together to continue to enhance the delivery of healthcare to our Nation's veterans.

Mr. Chairman, members of the subcommittee, this concludes my remarks. Thank you again for this opportunity to testify. My colleagues and I will be happy to respond to any questions from you and members of the subcommittee. Thank you.

[The statement follows:]

PREPARED STATEMENT OF HON. DAVID J. SHULKIN, M.D.

Good morning Chairman Kirk, Ranking Member Tester, and members of the subcommittee. Thank you for the opportunity to appear before you to discuss the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) fiscal year 2017 and fiscal year 2018 Medical Care Advance Appropriations budget request. I am accompanied today by Mark Yow, VHA's Chief Financial Officer.

The year 2015 was a big year in addressing some of the critical issues that we have before us in VHA. VA, as a whole, is working to rebuild trust with veterans and the American people, improve service delivery, and set the course for long-term VA excellence and reform. This initiative is called "MyVA." As we enter 2016, all of us in the VA healthcare system are focused on the "MyVA" initiative as well as VHA's Blueprint for Excellence. The Blueprint is aligned with the Department's Strategic Plan and supports the "MyVA" initiative. The Blueprint lays out themes and supporting strategies for transformation to improve the performance of VA healthcare now—making it not only more veteran-centric, but also veteran-driven by putting our customers in control of their VA experience. The Blueprint for Excellence will serve as a guide in all of the programs I mention throughout my testimony.

To ensure that we remain aligned with "MyVA" and the Blueprint for Excellence, I have five priorities that are the focus of VHA. First, we must fix the access issues and continue to work on reducing the wait time for veterans who need our services. Second, VHA must be a model for high-performance care and develop a high-performance network. Third, we must improve staff and employee morale and make VA a place where all of our employees feel comfortable and supported in an environment that allows them to do the best job to serve our veterans. Fourth, to ensure consistency of best practices and resource prioritization, we must share promising practices among facilities and focus on the things that we know are working best within VA. Finally, and most important, VHA must restore the trust and confidence that the American public and veterans have in the services that we provide.

The President's fiscal year 2017 budget request will support VA's goals to expand access to timely, high-quality healthcare; sustain funding to support programs dedicated to ending homelessness among veterans; and continue to transform the Department through its "MyVA" initiative, which reorients VA around veteran needs and empowers employees to assist them by delivering excellent customer service to improve the veteran experience.

The cost of fulfilling this care and other obligations to our veterans grows, and we expect it will continue to grow for the foreseeable future. We know that services and benefits for veterans do not peak until roughly four decades after a conflict ends. Therefore, more resources will be required to ensure that VA can provide timely, high-quality healthcare into the future. The fiscal year 2017 budget requests

additional resources, which are critical in providing veterans the care that they have earned through their service and sacrifice.

IMPROVED ACCESS TO CARE

VA is taking multiple steps to expand capacity at our facilities by focusing on staffing, space, productivity, and VA Community Care. The fiscal year 2017 budget request provides $65 billion for VA medical care, a 6.3-percent increase above 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, high-priority investments for Caregivers, and new hepatitis C treatments.

Building on momentum generated by the November 14, 2016, Stand Down, VA is continuing efforts to improve access to care, improve the veteran experience, and improve the VA employee experience by maximizing accessibility to outpatient services and initiating a second Stand Down held on February 27, 2016. We are re-focusing people, tools, and systems as we embark on a continuous improvement journey towards same day access for primary care and urgent specialty care.

We are empowering each VA facility to focus on the needs of its specific population under the aforementioned guiding principles. Clinical operations will meet customer demand through resource-neutral, continuous improvements at the facility level and scaling-up excellence across the enterprise.

VA has placed special emphasis on increasing access for veterans in rural and remote locations. Telehealth services are mission-critical to the future of VA care to veterans. Telehealth utilizes information and telecommunication technologies to provide healthcare services when the patient and practitioner are separated by geographical distance. The fiscal year 2017 budget requests $1.2 billion, an increase of $56 million (5.1 percent) above the 2016 enacted level for telemedicine. The number of veterans receiving care via VHA's telehealth services grew approximately 5 percent in fiscal year 2015, and is anticipated to grow by approximately 6 percent in fiscal year 2016. In fiscal year 2015, during more than 2.1 million telehealth episodes of care, VHA provided care to more than 677,000 veterans via the three telehealth modalities (i.e., Clinical Video Telehealth, Home Telehealth and Store and Forward Telehealth). Forty-five percent of these veterans lived in rural areas, and otherwise may have had limited access to VA healthcare.

We are appreciative of Congress' support to improve access as we build capacity within the VA system to better serve veterans who rely on us for healthcare. My testimony will now discuss key initiatives highlighted in the President's 2017 budget request.

MENTAL HEALTH CARE (SUICIDE PREVENTION—A CALL TO ACTION)

Long deployments and intense combat conditions require comprehensive support for the emotional and mental health needs of veterans and their families. Accordingly, VA continues to develop and expand its mental health system. VA has integrated mental health services into primary care in the Patient Aligned Care Team model. Providing mental healthcare within the primary care clinic minimizes barriers that may discourage veterans from seeking mental healthcare. This integrated healthcare is not seen in other healthcare systems nationally.

VA has many entry points for mental healthcare, including 167 medical centers, 1,035 Community-Based Outpatient Clinics and Outpatient Services sites, 300 Vet Centers providing readjustment counseling, 80 Mobile Vet Centers, a national Veterans Crisis Line, VA staff on college and university campuses, and a variety of other outreach efforts.

VA's Primary Care-Mental Health Integration (PC-MHI) program, which provides mental healthcare as a routine component of primary care, is now established in 98.8 percent of VHA divisions, 98.5 percent of the very large and 81.2 percent of large community based outpatient clinics. VHA provided over 1 million PC-MHI encounters in 2015, an increase of 8 percent from 2014 and an increase of 28 percent from 2013.

The fiscal year 2017 budget requests $7.8 billion, an increase of $347 million (4.6 percent), to ensure the availability of a range of mental health services, from treatment of common mental health conditions in primary care to more intensive interventions in specialty mental health programs for more severe and persisting mental health conditions. We will continue to focus on expanding and transforming mental health services for veterans to ensure that accessible and patient-centered care, including treatment for posttraumatic stress disorder (PTSD), ensuring timely access to mental healthcare, and treatment for military sexual trauma.

On February 2, 2016, Secretary Robert McDonald and I held a groundbreaking event "Preventing Veteran Suicide: A Call to Action." This day-long summit was at-

tended by over 230 participants, including members of Congress, the Department of Defense, other Federal partners, veterans, their family members, Veterans Service Organizations, academics, and other stakeholders. The primary goal of the event was to develop a concrete plan of action to engage more veterans at risk for suicide by bringing them into VA's system. Independent studies have shown that veterans who engage in VA care are at lower risk of suicide than those who do not engage in VA care. VA continues to develop a proactive action plan with steps to move forward with suicide-prevention efforts based on the feedback and presentations of the summit.

VA is committed to ensuring the safety of our veterans, especially when they are in crisis. Our suicide prevention program is based on enhancing veterans' access to high-quality mental healthcare and programs specifically designed to help prevent veteran suicide. Losing one veteran to suicide shatters an entire world. Veterans who reach out for help must receive that help when and where they need it and in terms that they value.

HEPATITIS C VIRUS

VA places a high priority on ensuring that all enrolled veterans who require treatment for the hepatitis C virus (HCV) have access to the necessary therapies. Chronic infection with HCV is the most common blood-borne infection in the world and is a major public health problem facing not only veterans, but the United States in general. The fiscal year 2017 budget requests $1.5 billion to capitalize on the availability of new therapies to improve access to and quality of HCV care. These new drugs will save veterans' lives. During fiscal year 2015, VA medical facilities treated over 30,000 veterans for HCV with these new drugs with remarkable success, achieving cure rates of 90 percent.

CARE IN THE COMMUNITY

VA is committed to providing veterans access to timely, high-quality healthcare. The 2017 budget includes $12.3 billion for Care in the Community and includes a new Medical Care in the Community budget account, as mandated in the VA Budget and Choice Improvement Act (Public Law 114–41). Of the total, $7.2 billion will be provided through a transfer of the 2017 advance appropriations for Medical Services to the new budget account, $250 million will be provided through anticipated collections in the new account, and $4.8 billion will be provided through the Veterans Choice Program. The 2017 budget will support over 15.6 million visits/procedures for veterans by non-VA providers.

On October 30, 2015, VA provided Congress with its plan for the consolidation and improvement of all purchased care programs into one New Veterans Choice Program (New VCP).

In today's complex and rapidly changing healthcare environment where VA is experiencing a steep increase in demand for care, it is essential for VA to work with providers in communities across the country to meet veterans' needs. To be effective, these relationships must be principle-based, streamlined, and easy to navigate for veterans, community providers, and VA employees.

CAREGIVER SUPPORT PROGRAM

VHA recognizes the crucial role that family caregivers play. These individuals are central to our mission in caring for those who have "borne the battle." They are partners in helping veterans as they recover from injury and illness, in supporting veterans in their daily lives in their communities, and in helping veterans remain at home. VHA is dedicated to providing caregivers with the support and services they need.

The fiscal year 2017 budget requests $725 million for the National Caregivers Support Program to support nearly 36,600 Caregivers, an increase of $102 million (16.4 percent) from fiscal year 2016, of which $629 million in 2017 will be for the monthly stipends paid to designated primary family caregivers under VA's Program of Comprehensive Assistance for Family Caregivers, an increase of $140 million (29 percent) from fiscal year 2016. The increases to the stipend obligations are due to an increase in the number of caregivers approved to participate in the Program of Comprehensive Assistance as well as the increases in the underlying hourly wages used to calculate the monthly stipend rates.

In addition to the Program of Comprehensive Assistance for Family Caregivers, VA offers a variety of services and resources through the General Caregiver Support Program, including: local Caregiver Support Coordinators, the National Caregiver Support Line staffed by licensed social workers, the VA Web site dedicated to family caregivers, as well as the Peer Support Mentoring Program. Additionally, VA offers

a variety of training and provides many educational opportunities for caregivers of veterans. VA is dedicated to promoting the health and well-being of caregivers who care for our Nation's veterans, through education, resources, support, and services.

ENDING VETERANS HOMELESSNESS

Ending and preventing veteran homelessness is now becoming a reality in many communities. Between 2010 and 2015, overall veteran homelessness dropped by 36 percent, as measured by the yearly Point-in-Time count, and we have achieved a nearly 50-percent decrease in unsheltered veteran homelessness. Through unprecedented partnerships with Federal and local partners, we have greatly increased access to permanent housing, a full range of healthcare including primary care, specialty care, and mental healthcare; employment; and benefits for homeless and at risk for homeless veterans and their families. As a result of these investments, in fiscal year 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.

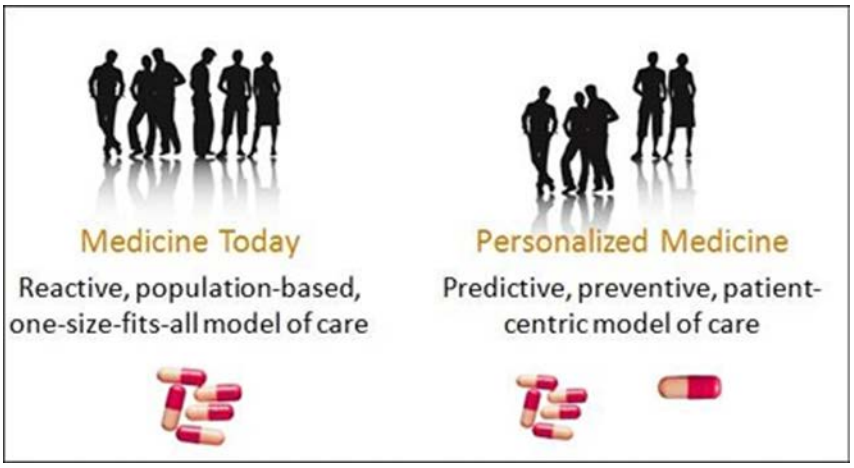
In fiscal year 2017, VA will continue to focus on prevention and treatment services. The fiscal year 2017 budget request of $1.6 billion will support programs such as Grant and Per Diem, Veterans Justice Outreach, Supportive Services for Veteran Families and case management services for the Department of Housing and Urban Development-VA Supportive Housing program. All of these programs will continue to work towards achieving a systematic end to homelessness, meaning that there are no veterans sleeping on our streets and every veteran has access to permanent housing.

ADVANCES IN MEDICAL AND PROSTHETIC RESEARCH

For over 75 years, VA Research has produced innovative and cutting-edge medical and prosthetic advances that are broad and significant. VA research is focused on the U.S. veteran population, and allows VA research to uniquely address scientific questions to improve veterans 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.

In 2017, Medical Research will be supported through a $663 million direct appropriation, and an additional $1.2 billion from VA's medical care program and other Federal and non-Federal grants. Total funding for Medical and Prosthetic Research will be over $1.9 billion in 2017.

The 2017 budget submission emphasizes transformational elements emanating from VA research and incorporating the evolving science of Genomic Medicine—how genes affect health—to support Precision Medicine innovations. This budget directly supports the President's initiative to invest in Precision Medicine to drive personalized medical treatment.



Beyond VA's support of over 2,200 ongoing 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. This initiative will focus on up to 21,500 veterans with PTSD, depression, pain, and/or substance abuse.

The second initiative will focus on additional analysis of Deoxyribonucleic acid (DNA) specimens already collected in the Million Veteran Program. 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 VA's 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.

CONCLUSION

In conclusion, VA is committed to providing the highest quality care, which our veterans have earned and deserve. I appreciate the hard work and dedication of VA employees, our partners from Veterans Service Organizations—that are our important advocates for veterans—our community stakeholders, and our dedicated VA volunteers. I respect the important role that Congress has in ensuring that veterans receive the quality healthcare and benefits that they rightfully deserve. I look forward to continuing our strong collaboration and partnership with this subcommittee, our other committees of jurisdiction, and the entire Congress, as we work together to continue to enhance the delivery of healthcare services to our Nation's veterans.

Mr. Chairman, members of the subcommittee, this concludes my remarks. Thank you again for the opportunity to testify. My colleague and I will be happy to respond to any questions from you or other members of the subcommittee.

Senator KIRK. Thank you. And, Mr. Pummill, after 30 years of service in the Army infantry, I will say—I want to say that you now should be addressed as Colonel Pummill.

VETERANS BENEFITS ADMINISTRATION

STATEMENT OF DANNY G.I. PUMMILL (RET.), ACTING UNDER SECRETARY FOR BENEFITS

ACCOMPANIED BY JAMIE MANKER, CHIEF FINANCIAL OFFICER

Mr. PUMMILL. Thank you, Chairman Kirk. Chairman Kirk, Ranking Member Tester, and members of the subcommittee, thank you for the opportunity to present VBA's 2017 budget request. I am accompanied today by Jamie Manker, our Chief Financial Officer. I am going to pose all the real tough questions to him.

Our 2017 budget request includes $2.8 billion in discretionary funds and $103.6 billion in mandatory funds, reflecting the ever-growing demand for VA benefits and services. The budget also requests a 2018 advanced appropriation of $103.9 billion for VBA's three mandatory appropriations, including compensation and pensions, readjustment benefits, and insurance indemnities.

The demand for benefits and services for veterans of all eras continues to increase and will continue to increase decades after conflicts end. For the past 15 years, the percentage of the veteran population receiving disability compensation has increased to 20 percent from 8.5 percent where it had remained steady for the past 40 years.

The average disability rating has also increased. For 45 years, the average disability rating degree of disability held steady at 30 percent, but since 2000 that has risen to 49 percent. Despite these challenges, VBA has made major strides in increasing productivity and reducing the claims backlog.

As a direct result of our transformation initiatives, we have reduced the pending disability claims inventory by 60 percent and the claims backlog by 87 percent. In making this progress, we also ensured that quality was not compromised. We have increased claim-based accuracy from 83 percent to 90 percent, and issue-based accuracy has improved to 96 percent. Veterans are waiting less time for decisions and benefits. The average time to decide a claim has improved by 90 days from fiscal year 2014, and the average age of a pending claim has improved by 188 days.

VBA is also working to further improve services to veterans in alignment with the Secretary's MyVA vision to become the number one customer service agency in the Federal Government. We are focused on improving veterans' experiences in the compensation and examination process as one of the Secretary's MyVA breakthrough priorities to help veterans better the exam process as it relates to their claims and enhanced procedures for exam scheduling. We are working on another MyVA breakthrough initiative to simplify and streamline the appeals process so veterans can receive their final decision on an appeal within 365 days from filing.

This budget supports this simplified appeals process which also requires Congress's continued support through legislative action. Our budget request includes funding for technology investments and other initiatives necessary to provide veterans, their families, and survivors with the benefits and services they earned and deserve. By moving to a paperless electronic claims processing system, VBA increased claim and medical issue productivity, which helped mitigate the effects of a 131-percent increase in workload between 2009 and 2015. The transformation from a paper intensive process to a full electronic processing system resulted in VA completing a record breaking 1.4 million disability compensation pension claims for veterans and their survivors.

Our technological advancements will expand and enhance existing services, and will also focus on delivering key functionality that enables quicker, more accurate and integrated claims processing. As VBA continues to receive and complete more rating claims, the volume of appeals, non-rated claims, and fiduciary exams correspondingly increase. To address this, we are requesting an additional $29.1 million for 300 personnel to process non-rating compensation and pension claims, as well as an additional $25 million to help meet veterans' expectations for more timely claim decisions.

We appreciate the opportunity to discuss our budget request and look forward to working with you to identify and prioritize spending in the best interest of our veterans, their families, and sur-

vivors, and our Nation. I welcome any questions you and the subcommittee may have.

[The statement follows:]

PREPARED STATEMENT OF DANNY G. I. PUMMILL

Chairman Kirk, Ranking Member Tester, and distinguished members of the Senate Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies: Thank you for the opportunity to present the President's 2017 budget and 2018 advance appropriations requests for the Veterans Benefits Administration (VBA). I am accompanied today by Mr. Jamie Manker, VBA's Chief Financial Officer.

SUMMARY OF 2017 BUDGET REQUEST

The President's 2017 budget for the Department of Veterans Affairs (VA) will allow VA to manage the comprehensive array of integrated benefits and services provided for our Nation's veterans, their families, and survivors, administered through our nationwide network of 56 regional offices (ROs). The 2017 budget request includes $2.8 billion in discretionary funds and $103.6 billion in mandatory funds for VBA. The budget also requests 2018 advance appropriations of $103.9 billion for VBA's three mandatory appropriations: compensation and pensions, readjustment benefits, and insurance and indemnities. With the resources requested in the 2017 budget, VA will provide:

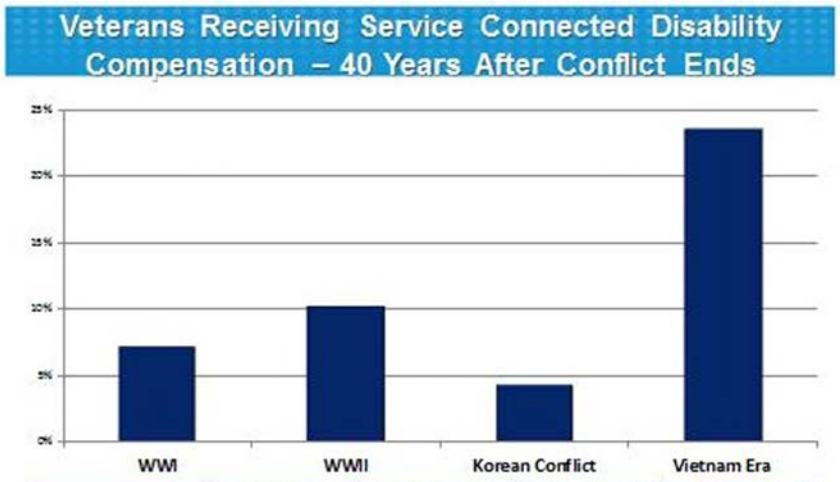
—Disability compensation for 4.4 million veterans with service-connected disabilities;
—Dependency and indemnity compensation for 405,000 veterans' survivors;
—Pension for 297,000 wartime veterans and almost 210,000 of their survivors;
—Vocational rehabilitation and employment benefits paid for nearly 141,000 disabled veterans;
—Education and training assistance for nearly 1.1 million veterans and family members;
—Home loan assistance for over 2 million veterans and family members with active VA loans;
—Fiduciary activities providing estate protection services for 224,000 VA beneficiaries unable to manage their own funds; and
—Life insurance programs for over 6 million veterans, servicemembers, and their families.

The President's 2017 budget request also includes funding for technology investments and other initiatives necessary to timely provide veterans, their families, and survivors with the benefits and services they earned and deserve.

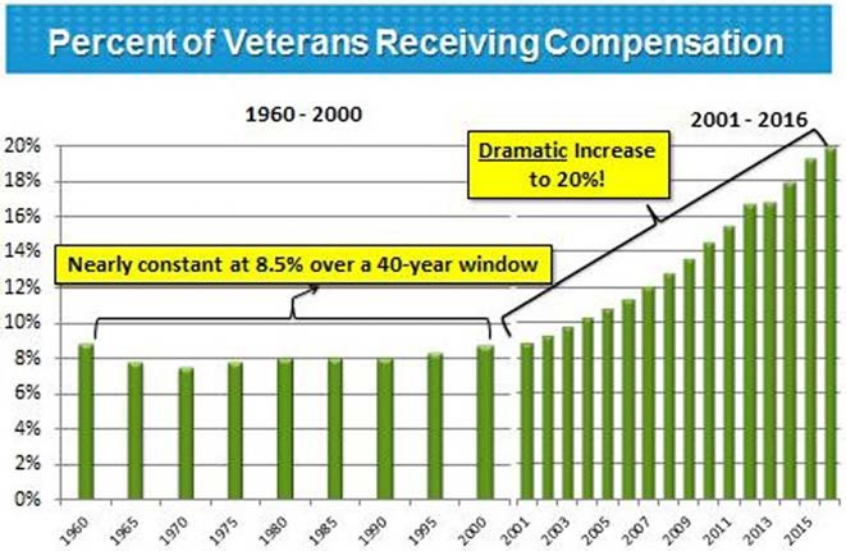
RISING DEMAND FOR DISABILITY BENEFITS

As VBA becomes more productive through our implemented people, process, and technology initiatives, the demand for benefits and services from veterans of all eras continues to increase, exceeding our capacity to meet it. This increased demand is fueled by more than a decade of war, agent orange-related disability claims, a disjointed and redundant claim appeal process, demographic shifts, increased medical issues claimed, and other factors. In addition, VBA is providing services to an older veteran population with more chronic conditions.

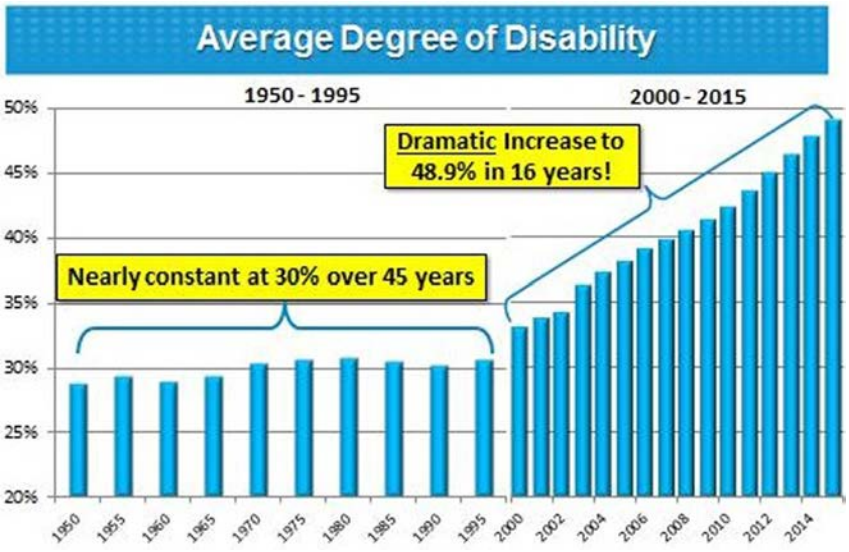
Veterans' benefit requirements continue to increase decades after conflicts end, which is a fundamental, long-term challenge for VA. Even though the Vietnam war ended 40 years ago, the number of Vietnam-era veterans receiving disability compensation has not yet peaked. We anticipate a similar trend for Gulf war-era veterans, of whom only 26 percent have been awarded disability compensation. For the past 15 years, the percentage of the veteran population receiving disability compensation increased to 20 percent from 8.5 percent where it had remained steady for over 40 years. Moreover, the total number of service-connected disabilities for veterans receiving disability 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, along with estimates based on historic trends, predicts an even greater increase in claims for more benefits as veterans' age and disabilities become more acute.



	World War I Veterans (1958)	World War II Veterans (1985)	Korean Conflict Veterans (1993)	Vietnam Era Veterans (2015)
SCD Compensation	203,654	1,048,976	198,492	1,664,385
Total Population	2,876,000	10,399,000	4,692,000	7,102,850
Percentage	7.08%	10.09%	4.23%	23.43%



Along with the increase in the number of veterans receiving disability compensation, there has been a significant rise in the average degree of disability compensation granted to veterans. 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.



CLAIMS PROCESSING TRANSFORMATION

VBA underwent the largest transformation in its history by modernizing the delivery of VA benefits and services. To achieve VA's goal of processing all claims within 125 days with improved accuracy, VBA aggressively implemented its transformation plan—a set of actions targeted to reorganize and retain its people, streamlined its processes, and deployed technology—and, as of January 31, 2016, VBA has achieved the following results:

—VBA is reducing the pending disability claims inventory.
  —Peak: 884,000 claims in July 2012.
  —Now: 352,554 claims—Improvement: 60 percent.
—Rating accuracy has improved.
  —12-month claim-based accuracy increased from 83 percent in 2011 to 90 percent—Improvement: 6 percentage points.
  —12-month issue-based accuracy increased from 95 percent in fiscal year 2013 to 96 percent—Improvement: 1 percentage point.
—Veterans are waiting less time for decisions and benefits.
  —The average time to decide a veteran's disability claim was reduced from 218 days in fiscal year 2014 to 128 days—Improvement: 90 days.
  —The average age of pending disability claims:
    —Peak: 282 days in March 2013.
    —Now: 94 days—Improvement: 188 days.
—Despite the challenges of an increase in disability claims workload as well as increased complexity of workload, VBA has made major strides in increasing its productivity.
—The number of claims pending over 125 days and considered part of the claims backlog has decreased.
  —Peak: over 611,000 claims in March 2013.
  —As of January 31, 2016: 79,106 claims—Improvement: 87 percent.

MYVA TRANSFORMATION—MEETING VETERANS' NEEDS

In addition to improving the quality and timeliness of disability claim decisions through our transformative people, processes, and technology initiatives, VBA is working to further improve services to veterans in alignment with the Secretary's MyVA vision: to become the Number 1 customer-service agency in the Federal Government. We are putting the needs and interests of veterans and their families foremost in all that we do.

VBA has realigned its ROs into 5 districts under the MyVA framework that simplifies internal coordination, facilitates partnering, enhances customer service, and allows veterans to more easily navigate VA. As the districts continue to mature,

there is increased coordination and collaboration among VA entities, veterans, community partners, and stakeholders to transform our agency into a more customer-centric organization. VA has enabled 36 Community Veterans Engagement Boards, a national network designed to leverage all community assets, not just VA assets, to meet local veteran needs. VBA ROs actively participate and engage with communities and Veterans Service Organizations (VSO) to focus on identifying solutions for veterans in the local communities and to establish the foundation for a strong MyVA community.

VA launched the Veterans Economic Communities Initiative (VECI) in May 2015 to complement the goals of MyVA and VA's Transition Assistance Program, promoting local collaboration, dialogue, and partnerships among organizations that serve transitioning servicemembers, veterans, and their families. Economic liaisons in each VECI community collaborate and partner with government leaders, businesses, policy experts, educational institutions, and nonprofit organizations to build an integrated network of support and resources and to maximize impact to improve outcomes for veterans and their families. We are expanding to 25 new VECI communities in early 2016, bringing the total to 50 U.S. metropolitan statistical areas.

One of VA's MyVA 12 breakthrough priorities is focused on improving veterans' experiences in the compensation and pension examination process. We are working to help veterans better understand the exam process as it relates to their claims. We are enhancing procedures for examination scheduling to facilitate veterans' direct involvement and providing training to ensure VA employees understand how their role directly impacts veterans' experiences and perceptions of VA.

We are also working collaboratively with our partners on the MyVA breakthrough priority to simplify the appeals process. Our goal is to provide veterans with a simple, fair, and streamlined appeals procedure in which they would receive a final appeals decision within 365 days from the filing of an appeal by fiscal year 2021. This goal would require Congress' continued support through legislative action and additional funding. The 2017 budget supports this simplified appeals process, which is explained in more detail later.

TRANSFORMATION INITIATIVES IN THE PRESIDENT'S 2017 BUDGET REQUEST

The MyVA transformation will ensure that VA is a sound steward of taxpayers' dollars as a result of instituting operational efficiencies, cost savings, and service innovations to support this and future budget requests. Few realize that when it comes to the general operating expense of delivering over $100 billion in benefits to over 5.3 million veterans and survivors, VBA spends only 3 cents on the dollar. To boost efficiency and employee productivity, VBA moved to paperless claims processing from its historically manual, paper-intensive process. Modernizing to an electronic claims processing system 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. The President's 2017 budget will allow VBA to continue building on the success of these initiatives.

Veterans Claims Intake Program (VCIP).—VBA shifted to electronic claims processing by converting paper files to eFolders through VCIP, which streamlined processes for receiving digital records and data into the Veterans Benefits Management System (VBMS) and other VBA systems. VCIP scans paper claims, converts them into digital format, and extracts important data for input into electronic folders. VBMS has also expanded document conversion services to include centralized mail processing. More than 1.9 billion images have been converted from paper, and over 99.8 percent of compensation claims are now being electronically processed in VBMS. In addition to supporting scanning operations and centralized mail processing, VBA's 2017 request of $142.9 million will sustain current operations, support future conversion efforts, and enable the disposition of paper materials.

Centralized Mail Initiative (CMI).—CMI consolidates inbound paper mail from VA's ROs to a centralized intake site, expands VBA's capabilities for scanning and conversion of claims evidence, increases electronic claims processing capabilities; and assists in converting 100 percent of received source materials to an electronic format. VBA has already deployed centralized inbound mail for all ROs. When coupled with VBA's contract examination vehicle, this will enable VBA to improve and enhance the speed and consistency for requesting VA examinations. The 2017 budget request of $26.7 million provides resources to sustain operations and expand this initiative to include in-bound and out-bound mail for all benefits through fiscal year 2020.

Veterans Benefits Management System (VBMS).—VBMS is a Web-based, paperless claims process solution complemented by improved business processes. As the cornerstone of VBA's claims transformation strategy, VBMS serves as enabling technology to provide veterans and their dependents with timely, high-quality decisions. VBA's shift to electronic folders in VBMS addressed the inefficiencies of the paper folders and the problems of misplaced files and records. Through a Web-based application, multiple, geographically separated users can view the electronic folders simultaneously, thereby minimizing the need for sequential processing and eliminating the delays of receipt of paper folders at ROs. VBMS also provides automation of processes, such as the receipt of evidence, movement of claims to the next stage, and updates to the claims status, which means more veterans are receiving faster decisions. As of January 31, 2016, VBA completed over 4.2 million rating decisions and processed over 2.4 million claims end-to-end in VBMS.

Under the VBMS initiative, we will continue to reduce our reliance on legacy systems with planned improvements to the electronic folder, such as adding a unique identifier on VA correspondence. When veterans return information with the identifier, it will automatically upload the information in the veteran's electronic folder. Both this fiscal year and in fiscal year 2017, VBMS enhancements will focus on delivering key functionality that enables quicker, more accurate, and integrated claims processing while laying the foundation for future, veteran-centric enterprise business capabilities. These include the delivery of electronic service treatment records, establishing one authoritative source for veteran contact information, and collaborating with the Board of Veterans' Appeals (Board) to define the appeals functionality needed both at the ROs and as part of the broader appeals modernization efforts. The 2017 budget request for $37.4 million for VBA and $143 million for the Office of Information &Technology (OI&T) provides resources to sustain operations and expand future enhancements and initiatives.

National Work Queue (NWQ).—In conjunction with VBMS, VBA is implementing a national workload strategy through NWQ, which will provide greater flexibility in management of workload and performance by enabling automated distribution of claims across VBA. NWQ prioritizes and distributes our claims inventory at a national level and further standardizes claims processing. NWQ will distribute claims electronically from a centralized queue based on RO capacity, so that veterans' claims will be automatically directed across all ROs to efficiently match claim demand with available expertise and processing capacity regardless of RO jurisdiction. Generally, the veteran's State of residence will continue to be the first filter for assigning claims, thereby increasing the likelihood that the RO in the veteran's State of residence will process the claim. Veterans are still able to receive assistance with their claims by visiting their RO for personal assistance at the public contact sites, going online through eBenefits, and utilizing VBA's National Call Centers. Veterans, congressional staff, and VSO representatives will continue to have access to claim status and information through current venues. The electronic inventory provides real-time updates, no matter where the claim is assigned for processing. The 2017 budget request of $3.3 million provides resources to fully implement the NWQ to all ROs and will expand this initiative to include electronically routing non-rating claims (claims that in most cases do not require a rating decision but directly impact benefits, such as survivors pension, burial claims, dependency claims, income adjustments, and drill pay adjustments).

NEW AGENCY PRIORITY GOAL TO IMPROVE DEPENDENCY CLAIM PROCESSING

As VA continues to improve timeliness of disability claim decisions, VA is now also focusing on the dependency claims that are the direct result of the dramatic increase in completed disability rating decisions and the growth in the number of veterans receiving compensation at the higher disability evaluation levels (30 percent and above). VA has established as one of its Agency Priority Goals (APGs) to reduce the overall inventory of dependency claims to 100,000 and improve the average days to complete (ADC) dependency claims to 125 days by the end of fiscal year 2017. Our improvement efforts include expansion of rules-based processing, promotion of online dependency claim submission, and streamlining of policies and procedures. The new dependency claims APG represents a 56-percent improvement from the fiscal year 2015 baseline of 227,000 pending dependency claims, and a 43-percent improvement from the fiscal year 2015 ADC baseline of 221 days.

ALL VBA BENEFIT PROGRAMS

The transition from a paper-intensive process to a fully electronic processing system resulted in VA deciding a record-breaking 1.4 million disability compensation and pension claims for veterans and their survivors in fiscal year 2015. VBA's suc-

cess in processing an unprecedented number of rating claims in recent fiscal years has also resulted in other unmet workload demands. With increases in rating claims receipts and completions, the volume of non-rating claims, fiduciary field examinations, and appeals increases correspondingly. To address this, VBA requests $2.8 billion for general operating expenses, an increase of $118.4 million (4.4 percent) over the 2016 enacted level. These resources will support 22,171 full-time equivalent (FTE) employees and includes an additional $29.1 million for 300 FTE to process non-rating compensation and pension claims. In 2015, VA completed nearly 37-percent more non-rating work than in 2013 and 15-percent more than in 2014. These additional FTE are needed to reduce the non-rating claims inventory and provide veterans with more timely decisions on non-rating claims. To ensure that all aspects of the claims process are improved for veterans, VBA is also requesting an additional $25 million to help meet veterans' expectations for more timely claim decisions, for a total increase of $118.4 million over the 2016 enacted level.

This budget will allow VBA to administer compensation and pension benefits totaling $86 billion to over 5.3 million veterans and survivors. It will also enable VA to administer education benefits and vocational rehabilitation and employment benefits and services to over 1.2 million participants; guarantee more than 429,000 new home loans; and provide life insurance coverage to 1 million veterans, 2.2 million servicemembers, and 2.8 million family members.

Insurance.—VBA's insurance program maintains life insurance programs, giving financial security and peace of mind to servicemembers, veterans, and their families. In 2017, we anticipate that our insurance programs will provide $1.2 trillion of insurance coverage to 2.2 million servicemembers, 1 million veterans, and 2.8 million spouses and children. The 2017 budget request for $35.4 million, of which $879,000 is in the general operating expenses appropriation and $34.5 million is reimbursable by the Insurance funds, will support 345 FTE and provide servicemembers and their families with universally available life insurance, as well as traumatic injury protection insurance for servicemembers.

Education.—VA's education programs provide education and training benefits to eligible servicemembers, veterans, and dependents. Education programs assist them in their readjustment to civilian life and also help the armed forces with recruitment and retention of members. In addition, these programs enhance our Nation's economic competitiveness by developing a more highly educated and productive workforce. Through the Post-9/11 GI Bill program, as of February 8, 2016, we have issued approximately $60.4 billion in benefits payments to 1,546,035 individuals and their educational institutions since the program's inception in August 2009. With the successful automation of Post-9/11 GI Bill claims, we are currently issuing benefits to the majority of beneficiaries in an average of 7 days at 99-percent accuracy. The 2017 budget request is $212.4 million and 1,904 FTE to continue providing veterans, servicemembers, Reservists, and qualified family members with such educational resources.

Vocational Rehabilitation and Employment (VR&E).—The VR&E program provides the services and assistance necessary to enable veterans with service-connected disabilities to become employable and obtain and maintain suitable employment, or, to the maximum extent feasible, achieve independence in daily living. VR&E services include career vocational counseling, job search assistance, and post-secondary training for service-disabled veterans. VBA seeks to enhance outreach and service delivery of education and vocational counseling services. Counselors from VR&E and Integrated Disability Evaluation System, as well as contract rehabilitation counselors will provide these counseling services through the VetSuccess on Campus programs at more than 94 schools.

Our alignment with the MyVA initiatives and objectives include investments in the Veterans Employment Center (VEC), which provides transitioning servicemembers, veterans, and their families with a single authoritative Internet source that connects them with job opportunities, and provides tools to translate their military skills into plain language and build a profile that can be shared—in real time—with employers. Employers have made commitments to hire over a million individuals and over 2.2 million private- and public-sector jobs are listed on the VEC. In addition, our Transition GPS program helps separating servicemembers prepare for civilian life by providing benefits briefings and other transition activities. So far, VBA has provided over 45,000 benefits briefings, career technical training courses, and support for capstone events to over 550,000 attendees. (Because servicemembers and their family members can attend more than one briefing, this count does not represent unique servicemembers). As previously mentioned, VBA is involved in the MyVA Economic Opportunity Campaign, which involves the collaboration with public and private partners in communities across the country to help connect and amplify available resources and support for veterans and their families.

The VR&E program request is $331.3 million and 1,594 FTE. This funding will help ensure that VA continues to build pathways to meaningful career opportunities for veterans by bringing them together with educators and employers across U.S. cities and communities and leveraging unique VA and interagency programs and resources to improve economic outcomes for veterans.

Home Loan Guaranty.—Our request of $170 million and 907 FTE for the housing program is funded through appropriations to credit accounts and helps eligible veterans, active duty personnel, surviving spouses, and members of the Reserve components and National Guard to purchase, retain, and adapt homes in recognition of their service to the nation. The 2017 budget includes $34 million for the VA Loan Electronic Reporting Interface (VALERI) to manage over 2 million VA-guaranteed loans for veterans and their families. 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. In addition to supporting the payment of guaranty and acquisition claims, it connects VA with more than 320,000 veteran borrowers and more than 225,000 mortgage servicer contacts. 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.

LEGISLATION

The 2017 President's budget also proposes legislative actions that are necessary to ensure that veterans receive timely and quality delivery of benefits. Designated as one of our MyVA breakthrough priorities, VA proposes to streamline and modernize the appeals process.

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 antiquated laws that have evolved since World War I 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 system has no defined endpoint, and multiple steps are set in statute. The system requires continuous evidence gathering and multiple readjudications 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. 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 appeal 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, 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.

Over the last 20 years, appeal rates have continued to hold steady at between 11 and 12 percent of completed claims. As VBA received and completed record-breaking numbers of disability rating claims, the number of appeals correspondingly increased. 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—between November 2015 and fiscal year 2027.

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 fiscal year 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 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 appeals 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; the veteran would be informed quickly whether that initial decision was substantially correct, contained an error that must be corrected, or was simply wrong. 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. If a veteran disagrees with any or all of the final appeals decision, the veteran always has the option of pursuing an appeal to the Court of Appeals for Veterans Claims or reopening the claim with new and material evidence.

VA firmly believes that justice delayed is justice denied. The VA team is passionate about fixing the broken, antiquated appeals process; this is a MyVA breakthrough priority. We look forward to working with Congress, veterans, and other stakeholders to implement improvements to provide veterans with the timely and fair appeals decisions they deserve and we appreciate the collaboration and feedback received from our ongoing discussions with Veterans Service Organizations on modernizing the appeals process.

CLOSING

Thank you for the opportunity to appear before you today to provide additional information on VBA's 2017 budget request. We are committed to administering benefits effectively and efficiently as responsible stewards of the taxpayers' dollars, while continuing to strive to improve the delivery of benefits and comprehensive information and assistance to our veterans, their families, and survivors. We are grateful for your continuing support and appreciate your efforts to pass legislation enabling VA to provide veterans with the benefits they have earned and deserve.

This concludes my remarks. I am happy to respond to any questions from you or other members of the subcommittee.

VETERAN CRISIS LINE

Senator KIRK. Let me ask the first question here. Over the weekend I met with the family of Illinois Army Specialist, Tom Young, who has served two tours in Iraq with the 10th Mountain Division. This 30-year-old father of Vivian and Maggie called your suicide hotline looking for help, but was sent to voicemail. Afterwards, he laid down on the metro tracks near the Prospect Heights train station and was killed by an oncoming train. The next morning, Tom's family answered the call from the Veterans Crisis Line calling him back telling him that there were beds available.

Three weeks ago, the VA inspector general released a report on the suicide hotline calls being sent to voicemail or answered by staff who are not properly trained. Just last week, Deputy Secretary Sloan Gibson said that the report was based on old data and that VA had taken steps months ago. Question for you. If the changes occurred months ago, how could Tom Young have been sent to voicemail just 7 months ago?

Dr. SHULKIN. First of all, this is a terrible tragedy that happened to Tom Young, and should never happen, and is totally unacceptable. The inspector general report that was mentioned found that there was an episode of approximately a two-week period of time

in 2014 where calls went to voicemail was also unacceptable. This actually happened with a contractor. This was not the VA staff at the service line when——

Senator KIRK. David, let me follow up.

Dr. SHULKIN. Yes.

Senator KIRK. Who is responsible for the Veterans Crisis Line under you? I would just like a name.

Dr. SHULKIN. Yes. His name is Matt Eitutis.

Senator KIRK. Matt Eitutis.

Dr. SHULKIN. E–I–T–U–T–I–S. That is a recent change that we put in place. After the inspector general report came out, we made a management change. We put this under professional business practices, and we are doing everything that we can. And steps have been taking place over the last year to update the technology, the staffing, the physical location. And our goal, it is one of our priorities in the Secretary's MyVA initiative, is to make sure that these calls are answered by VA staff, and that they do not roll over to secondary contractors.

Senator KIRK. When you say there was a contractor involved, who was the contractor involved?

Dr. SHULKIN. It is—Senator Kirk, I will get you the specific name. It is—we use an acronym, something—I do not want to say the wrong name. I would probably get another company in trouble that have nothing to do with this, but——

Senator KIRK. But, David——

Dr. SHULKIN. Yes.

Senator KIRK [continuing]. My staff has been trying for weeks to find out who was the person responsible for the Veterans Crisis Line. It is almost impossible to find out.

Dr. SHULKIN. Oh, yes. You know, I know that your office had a name, that that person has now subsequently left. If you tell the time period you are looking for, Senator, we can get you a specific name.

Senator KIRK. The time period that I am most interested in——

Dr. SHULKIN. Yes.

Senator KIRK [continuing]. Is when my constituent called the crisis line. You know, for a veteran to admit that there is a big enough problem that he is contemplating a suicide, that is a huge decision to get on the phone with the Veterans Crisis Line.

Dr. SHULKIN. Absolutely.

Senator KIRK. And we are dealing with a very fragile person. In the case of Tom Young, he just walked in front of the train and got killed.

Dr. SHULKIN. This is—as I said, there is no excuse for this. The Veterans Crisis Line saves lives every day. They actually have referred 11,000 veterans to emergency services, dispatched ambulances, saved lives every day. These are some of the hardest working staff in the VA. This is a tough, tough job. They do miraculous things.

But the phone calls have to be answered. That is why we have put new management in place. We are not going to accept even a call—there is no voicemail today, I can assure you that. That is unacceptable. That was done by a contractor.

Senator KIRK. Great.

Dr. SHULKIN. But absolutely, we will get you that name, but we are working extremely hard. This will not happen again, but these people are being supported the way that they need to answer those calls.

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

Senator KIRK. One of the acting directors of mental health operations in 2014, at the time of the Office of Inspector General investigation, was Ira Katz. Was he the same Ira Katz who, according to CBS News, in 2008 covered up the veterans suicide rates leading both Senators Akaka and Murray to call for his resignation?

Dr. SHULKIN. Senator, Dr. Katz is a psychiatrist who works out of our Philadelphia area.

Senator KIRK. So you had two United States Senators at the time of the congressional majority calling for his resignation, and he is still on the job.

Dr. SHULKIN. Dr. Katz is actively on the job. I am actually not aware of what the specific issues were with the Senators. So, again, since I am not aware of exactly what those allegations are——

Senator KIRK. If the Choice Act gave you the authority using the Secretary's authority to fire employees, could you consider getting rid of Ira Katz when Senators Akaka and Murray have already called for him to resign?

Dr. SHULKIN. Well, I will commit to you today that I will go back and look into those issues. But any time there is an allegation, it is our responsibility to make sure that we look into it, that we have an objective evaluation, but we do make our disciplinary decisions based upon that.

I happen to have known Dr. Katz for about 25 years. He is a well-respected psychiatrist. But I absolutely will go back and make sure that we look into that and provide follow up.

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

Senator KIRK. Thank you.

Mr. Tester.

Senator TESTER. Go with Tom.

Senator KIRK. Mr. Udall.

ACCESS TO CARE

Senator UDALL. Thank you. Thank you very much, Mr. Chairman. And, Dr. Shulkin and Mr. Pummill, thank you for taking the time to speak here and be with us today. Almost more than any other issue that we work on here in Congress, helping veterans access benefits and healthcare is one of the most important services my office offers to veterans.

But it is also one of the most frustrating. As I have said here before, the majority of veterans are satisfied with the care they receive from the VA when and if they can get it. And I would just underline that "when and if they can get it." Most veterans I have spoken to believe that the care you provide is second to none, and this budget helps support that. This budget, however, also helps to ensure that the VA's care remains in place for the future and that improvements are made where care is lacking.

OPEN AIR BURN PITS REGISTRY

Dr. Shulkin, I am glad to see that the VA's budget justification specifically supports research into exposure to airborne particulate matter from burn pits. The Open Air Burn Pit Registry is the result of a bill I authored. National Guardsman Master Sergeant Jessey Baca, and his wife, Maria, of Albuquerque were the driving force behind this effort. Jessey has battled cancer, bronchiolitis, PTSD, and numerous other ailments believed to be connected to his contact with toxic burn pit fumes while deployed in Iraq.

In last year's omnibus, I secured a provision requiring the VA and the Department of Defense (DOD) to share information about when and how servicemembers may have been exposed to airborne hazards and open burn pits. Does the new research called for in the fiscal year 2017 request include data from DOD and the Open Air Burn Pits Registry?

Dr. SHULKIN. Well, first of all, thank you. Thank you for that bill. I think that that is very, very important for us to fulfill our mission to the veterans who served in Iraq and Afghanistan. As you know, we have 45,000 veterans who have registered into your registry. And we are working with DOD to do interagency cooperation exactly as you have suggested to be able to study this.

Our research will be active this year. As you know, we worked with the Institute on Medicine, the National Academy of Sciences in the past to look at this issue. Some of those questions actually that were asked about the exposure and the risk hazard, there was not enough evidence. So we do need to continue that research, and that is something that we are committed to making progress on in our current fiscal year.

The registry helps us considerably in being able to track these long-term outcomes of the veterans. So thank you, and, yes, we are committed to following up on that.

APPEALS BACKLOG

Senator UDALL. Great. Thank you very much. And, Mr. Pummill, I am happy to see that the Albuquerque VA has made significant progress, the percentage of backlog claims from around 60 percent in 2013 to 20 percent just last month. However, more veterans are unhappy with the decisions on their claims, which has led to more appeals. What can be done to make sure the appeals process does not fall victim to the same backlog that we saw in initial claims while also guaranteeing appeals receive the due process they deserve?

Mr. PUMMILL. Senator, that is an excellent question. Appeals is the number one concern for VBA right now. The Secretary has directed us to get with our constituents and figure out how to resolve the current appeals process. We are meeting next with the VSOs, the veterans service organizations, the State and county veterans service organizations. We are basically locking everybody in a room for 3 days, and the Secretary told us you do not leave the room until you come up with something that you can present to the Congress to change the way that we are doing appeals right now.

The appeals process is tied up in laws. It is one of the most complicated processes that exist in the Federal Government. We are

going to need some kind of legislative change. What we need to present to you is something that we, the VSOs, and the veterans all agree that is the right thing to do so that we can offer that legislative change.

Senator UDALL. Thank you for that answer. And I have a couple of other questions—I am near the end of my time here—on reform of the Comp and Pen exam, and also rural telehealth, which I think is very, very important to our vets. And I see that you are trying to increase investments in that area and get additional telehealth out into rural areas. So I will submit those for the record and yield back, Mr. Chairman. Thank you.

Senator KIRK. Mr. Tester.

MONTANA'S CHOICE PROGRAM WITH HEALTH NET

Senator TESTER. Thank you, Mr. Chairman. Dr. Shulkin, in my opening remarks, I talked about the problems veterans are having in Montana. Could I get your personal assurance that you will directly engage in the efforts to address the frustrations with veterans in my State with the Choice Program, specifically with Health Net?

Dr. SHULKIN. Yes, Senator. In fact, we have committed to having a team out to Montana. That is going to be the week of March 28th where Dr. Yehia and his team will personally be there to meet with Health Net and with your staff, as well as the staff at VA to work this out.

IMPROVING VETERANS ACCESS TO CARE IN THE COMMUNITY ACT

Senator TESTER. Good. I want to follow up with you, but we can do that offline as we move forward.

So, while pushing to make changes, I also fully recognize that Congress needs to do what we need to do to allow you to do your job. Today with a number of my colleagues, including Senator Udall and Blumenthal, I am introducing legislation called the Improving Veterans Access to Care in the Community Act. This bill includes a number of provisions, many drafted in consultation with the VA and other stakeholders, that will greatly empower your efforts to deliver more timely and quality care for our veterans.

By including provider agreement language sought by the VA, this legislation would ensure that you are able to provide care in the community for veterans in a timely manner. Would you agree with that?

Dr. SHULKIN. Absolutely would agree with that.

Senator TESTER. Okay. The VA has previously said that a failure to address this issue would have enormous negative impacts on veterans' access to healthcare. A huge issue.

Dr. SHULKIN. We are seeing this every day, Senator.

Senator TESTER. So you would agree with that statement, too.

Dr. SHULKIN. I would.

Senator TESTER. Okay. By providing funding—spending—I am sorry. By providing spending flexibility across community care programs, this legislation would provide the VA with the ability it needs in places like Montana and other areas, by the way, to steer veterans to care in the manner that makes the most sense for that veteran. Would you agree it would do that?

Dr. SHULKIN. It absolutely will. It will help simplify the program for veterans, no question about it.

Senator TESTER. Okay. And by consolidating the VA's multiple community care programs, and there are many, into one single program with consistent and streamlined eligibility criteria and administrative rules, that that would reduce the confusion for veterans and VA employees alike. Is that correct?

Dr. SHULKIN. Yes, seven programs at least into one would be very helpful.

Senator TESTER. Okay, and streamlined.

Dr. SHULKIN. Streamlined.

Senator TESTER. Smooth.

Dr. SHULKIN. Exactly.

Senator TESTER. No red tape, or minimal. Let us put it that way.

Dr. SHULKIN. Yeah.

Senator TESTER. And it would greatly reduce administrative burdens for the community providers, too, then.

Dr. SHULKIN. Provider agreements and the streamlined funding would make it easier for community providers by a huge amount, Senator.

Senator TESTER. So you would anticipate that it would make it—this Choice Program better for the providers and, thus, entice them to come on board.

Dr. SHULKIN. And I would hope your largest provider in Montana would consider coming back.

Senator TESTER. Well, so do I. Together all of these things would assure that the VA is better able to utilize the tools at its disposal to better meet the healthcare needs of veterans. You would agree on that also.

Dr. SHULKIN. I would.

Senator TESTER. Okay. So we are going to be working with Chairman Isakson and others hopefully in this room so that we could get this to the President as quickly as possible.

VBA BUDGET REQUEST

I got about a minute and a half in this round. Mr. Pummill, how does this budget ensure that the VBA is able to fulfill its mission 1 year down the road, 5 years down the road, even 10 years down the road?

Mr. PUMMILL. We are going to have to take the budget that you have provided to us, which I believe is an appropriate budget, and with the proper training of the people that we have on board, and with automation, take care of the needs of the veterans into the future. We know just from past history that 20, 30, 40 years after a conflict, as veterans age we get a large number of veterans coming in for increased benefits and services.

We have to be prepared for the Iraq and Afghanistan veterans that come in requesting those services in the future. We just need to capitalize on our automation systems and our training to make sure we are ready for them when they come.

MILITARY SEXUAL TRAUMA ADJUDICATION

Senator TESTER. Could you speak specifically to the progress that is being made, if any, and I hope there is being progress made on

this, by the way, to more properly adjudicate claims involving military sexual trauma?

Mr. PUMMILL. Yes, we have made massive and substantial changes in how we do military sexual trauma (MST). We have actually trained people—there is at least one person in each RO that specializes in that now so that they understand that it is something that is not always right out front in somebody's military records, that you have to dig and you have to find the markers that support that.

Senator TESTER. Okay. To test this a little more, do you believe that the standards for adjudicating PTSD claims from combat trauma should be the same standards used to adjudicate PTSD from claims from MST?

Mr. PUMMILL. I believe that PTSD is PTSD. It should be the same.

FULLY DEVELOPED CLAIMS EXPEDITED PROCESS

Senator TESTER. Okay, thank you. Earlier this year I introduced legislation with Senator Sullivan and some others that would provide veterans with the option of filing a fully developed appeal that would be adjudicated through an expedited process. Do you support that? Do you think it is a step in the right direction?

Mr. PUMMILL. I think it is a step in the right direction. That is one of the things that we are going to be pushing at our meeting next week.

Senator TESTER. Do you think other changes need to be made?

Mr. PUMMILL. Yes, I do.

Senator TESTER. What are they?

SIMPLIFY APPEALS PROCESS

Mr. PUMMILL. We have to simplify the appeal process so that there are not so many bites at the apple. The best example is a veteran who has been appealing for 25 years and has added 27 different variances to his claim as he goes through. That ties up the whole system. It is just a waste of everybody's time.

Senator TESTER. Do you have any statistics on claims that are put forth that are bogus?

Mr. PUMMILL. Not off the top of my head. I do not know. We would have to get back to you on that. Frankly it is my experience, it is not very high. The vast majority of veterans are honest and forthright. They are just frustrated about how long things take. I do not see very much fraud, to be honest with you.

Senator TESTER. Okay. I will wait for the second round. Thank you, Mr. Chairman.

Senator KIRK. Mr. Schatz.

TELEHEALTH AND TELEMEDICINE

Senator SCHATZ. Thank you, Mr. Chairman. Dr. Shulkin, I wanted to talk to you about telemedicine and telehealth. I know VA has done leading-edge work in this space. I want to—I want to ask you two questions. First of all, generally speaking, where do you see the future opportunities in telehealth and telemedicine in terms of serving veterans?

Dr. SHULKIN. Very briefly, Senator, VA is actually the largest provider of telehealth services, 2.1 million visits last year, but we need to be doing much more. We need to be going to mobile devices because that is where people are carrying their information. And we need to be using telehealth as a way to keep veterans at home and out of institutions, and having to have them travel several hundred miles to reach facilities. They should be able to get the care where they are.

Senator SCHATZ. So we have a different problem on the Department of Health and Human Services (HHS) side. They lack some of the statutory authorities that you have. But I have a concern in terms of funding requests because it seems to me that you—and this is great. You expect the number of veterans receiving telehealth services to increase by 12.6 percent through 2017, but you have asked for a roughly 5 percent increase in funding. Now, that may be because this is a highly leveraged thing, but I want to—I want to understand that discrepancy.

Dr. SHULKIN. Yeah. VA, because of its early adoption of telehealth because, frankly, we have needed to do this, has invested hundreds of millions of dollars in infrastructure that can be leveraged, and we can add to its capabilities without dollar-for-dollar investments.

Senator SCHATZ. How did you get to the 12.6-percent target?

Dr. SHULKIN. The 12.6-percent target was done out of our—out of our projections, out of our enrollment projects, and targeting specific areas that we believe that we can expand. Quite frankly, I think that is conservative when you see what is happening in the healthcare industry. We are seeing much, much larger increases year to year. And so, I think that that will be a conservative estimate.

Senator SCHATZ. How much of the challenge is introducing patients to telemedicine, you know, at the front end? It seems to me that on the one hand for psychology, psychiatry, case management in terms of mental health services, there might be less—eventually less of a barrier to accessing services. But on the front end, it may just seem odd for people to utilize a device to get the services they need. So how are you dealing with that sort of getting the veteran through the threshold?

Dr. SHULKIN. Well, you know, as you know, I have spent my career in the private sector, so coming into VA months ago this was one of the surprises, how many different specialties VA is using telehealth in. It is doing teledermatology, telepathology, teleradiology, telehepatology. I mean, all sorts of things.

And we have studied the acceptance use of veterans, and it is sky high. It is in the 90s, and we are publishing on this now. So the acceptance really has been extraordinary because it saves a veteran from sometimes having to travel hundreds of miles, and they are getting the care that they need.

Senator SCHATZ. Absolutely, and thank you for your good work in this area. You can count on me to try to support this as much possible. And if you can keep talking to HHS, we would really appreciate it as well.

Dr. SHULKIN. Sure, absolutely.

ELECTRONIC HEALTH RECORD AND GAO HIGH RISK LIST

Senator SCHATZ. I want to talk to you about the electronic health records. I was told that the initial read-only version of the system would be available by the end—would be available on some sites in 2015 with full deployment by 2018. But last fall, GAO testified that you are not on track. DOD is not on track. And so, my question is, what is the new timeframe, and when do you anticipate being taken off the GAO's high-risk list?

Dr. SHULKIN. Okay. I think there are a couple of questions there. I think your question about the electronic medical record is about interoperability with the Department of Defense?

Senator SCHATZ. Yes.

Dr. SHULKIN. We currently have a joint viewer up and operational. In fact, 35,000 VA providers are actively using this today. So if you come into a VA, we are able to access through what we call the joint viewer DOD records. So we are currently operational, and would be glad to demonstrate that for you if you are open to that, how that is working.

The GAO high-risk list, we were put on that list by GAO not specifically because of the electronic medical record, but many other issues. We, again, are meeting with GAO on a regular basis and actively working that list down to close all the recommendations. And you do not come off the GAO list very quickly. You really have to demonstrate that you have addressed these commitments. And so, we are working towards that. We hope that we are making good enough progress to be able to give an indication of where are towards the end of the year.

Senator SCHATZ. Thank you.

Senator KIRK. Mr. Boozman.

Senator BOOZMAN. Thank you, Mr. Chairman, Ranking Member. Thank you all very much for being here. We appreciate your hard work.

STANDARD PRODUCTIVITY MEASURES

Dr. Shulkin, I know that one of the things I have been pleased with that you all really are trying to do a good job regarding metrics, measuring things. In regard to being able to determine the cost associated with providing care versus buying care in the community, I know your IT infrastructure is maybe not quite as good as you would like for it to be. Can you talk a little bit about that and how you are trying to determine that, again, in a difficult environment?

Dr. SHULKIN. Right. Thank you, Senator. We are very data rich at the VA. It is one of our strengths, why we have been able to drive improvements particularly on the clinical side. And wherever we can, we are trying now to use metrics that we can compare to the private sector because I think that is appropriate. In fact, we have too many metrics, so we are trying to pare it down to what is most important.

The area that we struggle the most with are financial comparisons because what we do in the VA does not directly compare always—sometimes it does, but does not always directly compare to the private sector. So we have begun to measure relative value

units (RVUs), so we know—which is standard productivity measure both in the private sector and the VA, so we can tell you VA actually increased its RVU, its productivity measures, 10 percent last year.

The direct financial comparisons are a challenge, so what we are beginning to do is to ask specific questions. What would it do for an eye exam in the VA healthcare system versus outside? And so, we are going to be making specific choices about what is better for veterans, what is better for taxpayers as part of the new Veterans Choice Plan to bring those financial considerations in place.

And let me just ask whether our Chief Financial Officer has a better or more specific answer about these comparisons.

Mr. YOW. One of the challenges we have had is we do a lot of things in the VA that are not comparably done in the private sector, things like homeless programs, things like the fact that we have a richer mental health benefit, things like if we have a richer long-term care benefit program than in the private sector insurance would have.

So when we get asked questions like cost per RVU, it really becomes an apples and oranges comparison unless we try and drill down and get that further. And our systems are so old right now, it is very difficult for us to go through to get that granularity to do that. It is not for lack of wanting that we have not been able to do it thus far.

HEALTHCARE FACILITIES BUDGET REQUEST

Senator BOOZMAN. Very good. Not in follow up, but another question to our chief financial officer, the VA budget requests $836 million for the activation of new and enhanced healthcare facilities. What are the VA's priorities for the upgrades? How much of this funding will be used for new facilities versus enhancements? And has the VA determined where the projects will be located?

Mr. YOW. Yes, sir, we have a list that we provided the staff, and we can provide that to you again, the specific projects locations. They are all from what we call major construction or major lease projects, so they are essentially new facilities more so than renovations or replacement leases. That is where we fund activations from.

It primarily does two things. It does what we call non-recurring cost, initial outfitting, if you will, of a new facility, things like equipment, supplies, and so forth, to get it ready to open its doors. And then recurring costs for about a 2- to 3-year period as they prepare to open their doors and make their way into the healthcare projection model and get funding for them into the future.

So, for example, if it is a recurring lease and there is no new staff, they would not need as much recurring funding. But if it is expanding or a brand new facility, we would have to hire new staff as well. So it varies a great deal by project.

Senator BOOZMAN. And the average age of our infrastructure is what, 50?

Dr. SHULKIN. We have about 60 percent of our facilities are 50 years old or older.

Senator BOOZMAN. Very much. Thank you, Mr. Chairman. Thank you. Thank you, guys.

Senator KIRK. Mr. Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman. Thank you all for your fantastic work.

OTHER THAN DISHONORABLE DISCHARGE

You are probably aware of reports that the U.S. Army has forcibly separated over 22,000 soldiers for misconduct after they return from deployment in Iraq and Afghanistan that were also diagnosed with mental health problems or traumatic brain injury (TBI). As a result of this disclosure, the Army inspector general and the surgeon general are going back and doing a review of those 22,000 cases and apparently are going to make recommendations as to some of them and some recommendations going forward.

But as I understand it, the VA looks at the character of discharge to determine whether a person meets the basic eligibility requirements, and you determine whether the incidents that led to the discharge are found to be under conditions other than dishonorable. So you have essentially a chance to look at those conditions of discharge and make a determination as to whether they would be able to be able for benefits.

So I do not know whether this is a question for you, Dr. Shulkin, or for you, Mr. Pummill, but to ask a question about what has the VA done in the wake of this disclosure, and pending this review that is happening in the Army, what can you do to perhaps remedy some of those 22,000 who should have not been given a discharge under non-medical terms?

Mr. PUMMILL. Yes, Senator. First of all, it is a serious concern for the VA. We know that most of these men and women are going to end up homeless, that they already have one foot in a bad place, and this does not help. Some of the things that we—first of all, we cannot change the character of discharge. Only the military service can do that. We do contact the veterans. We advise them how to get to the Army Board for Correction of Military Records or the equivalent in the other services so they can request a change in their discharge and upgrading their discharge.

We have worked with the services. The services have sent out letters to veterans saying, hey, if you feel that your discharge may have been improper because of something that happened to you in combat or deployment, please come back, file your paperwork. They are not getting a very high response rate, so we sent letters out underneath the Under Secretary of Benefits' signature to those same veterans to see if maybe a letter from the VA saying, hey, go back to your military department, if we could help it out.

Senator MURPHY. But let me just clarify.

Mr. PUMMILL. Certainly.

Senator MURPHY. My understanding is that you have the ability to review the circumstances of the discharge. If there is a discharge for misconduct, you are saying their only recourse is to go back to have the conditions of discharge changed.

Dr. SHULKIN. Senator, that is our understanding that this is a Department of Defense decision. This is not a VA decision. And we are prohibited by law from treating somebody in what we call bad paper, a dishonorable discharge.

Senator MURPHY. And that is your understanding as well?

Mr. PUMMILL. It is my understanding that we cannot change the character of the discharge, Senator, yes.

Senator MURPHY. Okay.

Dr. SHULKIN. One of the things that VA is doing because they take this very seriously, and I know this is where you are coming from, too. It is one of the reasons why we have worked so hard to develop strategic partnerships with community groups because when we find these veterans and they show up at VA, we are working with community groups to actually help in the treatment of these patients.

Senator MURPHY. Mr. Chairman, I just want to underscore this, and Senator Tester has been a great leader on this. There are 22,000 veterans out there today just since 2009——

Senator KIRK. Yes.

Senator MURPHY [continuing]. Who have been discharged for misconduct, who prior to that discharge had a diagnosis of TBI or PTSD. There is an ongoing investigation as to the circumstances of those discharges. We as a subcommittee have to grapple with the fact that you have—it is not just what we know about it, right? Twenty-thousand brave men and women who were potentially wrongfully discharged for misconduct who cannot access VA services who are going to be out on the streets. So I would love to follow up with you——

Mr. PUMMILL. Yes.

Senator MURPHY [continuing]. On this topic to think about ways in which—while this review is happening. I have asked for a moratorium on discharges for misconduct with respect to individuals who have been diagnosed with PTSD or TBI during this period of review. The Army has not looked favorably upon that request, so the numbers are just going to continue to mount.

I have another question, but I will put it in for the record.

CONNECTICUT CAMPAIGN TO END CHRONIC VETERAN HOMELESSNESS

Senator MURPHY. I just want to thank you for your work with Connecticut on our campaign to end chronic veteran homelessness.

Dr. SHULKIN. Congratulations.

Senator MURPHY. We are the first big State in the Nation to do that.

Dr. SHULKIN. Yes.

Senator MURPHY. And that is a consequence of a dramatic increase in HUD vouchers, which we desperately need to keep or we will slide back on that commitment. But it is also a consequence of your very successful integration of mental health services with physical help services that has allowed us to make those great gains. And I congratulate you on doing something in the VA that the private sector should be doing at a much greater rate.

Dr. SHULKIN. What we have learned, Senator, is this is all about working with the community, and the Connecticut leadership coming out of the Governor and your community groups have really—they deserve the credit for this. And we thank you for your support.

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

Senator KIRK. Senator Cassidy.

Senator CASSIDY. Dr. Shulkin, you have got an impressive resume, man. I wish my resume looked like yours.

Dr. SHULKIN. I think you are doing all right.

Senator CASSIDY. My son does not think so, but that is a son, huh? We are both physicians, so as you know there is a collegiality. I will go around the country and visit with different—Murphy and I have this connection with mental health, so the mental health folks in the VA will come and approach me. I have learned, at least this is a little bit dated, but your administration is new, so I will ask you again to see if it has changed.

MENTAL HEALTH NO-SHOW RATE APPOINTMENTS

There is great variability in the systems used for mental health. I gather there might be a place in Kansas which is really working well, but you go elsewhere and the doc will, say, oh, yes, if they miss their appointment, they are scheduled 3 weeks later. The better system is to leave some slack at the end of the day, and to know that there are going to be a certain percent late, but that some of the folks will, you know, frankly be pleased that they are less busy.

To what degree do you have the ability to look at no show rates, average time to rescheduling, average time for new appointment, et cetera, and compare them against one another? If you are able to do that, what is the current variability between different clinics?

Dr. SHULKIN. Excellent questions. We have a 20-percent-plus no-show rate in mental health appointments.

Senator CASSIDY. Now, is that standard or, no, here it is three, and there it is 60?

Dr. SHULKIN. There is a wide spectrum. And so, what you are describing is the situation that I found when I came in, which is that VA has tremendous variability in many of these clinical measures. And what healthcare systems that are accepting the challenge of being healthcare systems are doing now are decreasing that variability. They are identifying best practices and standard——

Senator CASSIDY. Totally get that. So that is what your expertise is.

Dr. SHULKIN. Absolutely.

BEST PRACTICES SYSTEM

Senator CASSIDY. To what degree can I go to a clinic now that formerly told me, oh, man, we got all kinds of no shows, and I cannot get anybody to change it, to, no, we actually have the system such as best practices?

Dr. SHULKIN. The first thing that we have done already is we have identified these best practices. We had a call for best practices in the last month where we identified 250 of the best practices in VA, many related to access. Today we have brought in those best practice leaders to share and map out their best practices. Tomorrow we are bringing in the industry leaders in how to do best practice implementation to advise VA.

We are committing towards the end of the year to have these best practices in place. It is exactly what we need to do, and it relates to what the GAO found that put us on the high-risk list.

Senator CASSIDY. So I know that—again, you and I both know this—in healthcare systems, it is data, data, data. To what degree can you share with each of us as regards what the institutions in our State are doing at this moment in time, and then the trajectory of how they are improving over time.

Dr. SHULKIN. Be glad to do that. VA is actually very good at producing those metrics. We have clinical metrics, outcomes called the sail measurement system, which we can share with you and show improvement, or actually those that are not improving, and on access measures, lots of data that we can share and other process measures. And, in fact, we are targeting this. This is one of my five priorities to implement these best practices.

FRONT LINE DISCIPLINARY ACTION

Senator CASSIDY. Now, also related to all this, again, the kind of conversation someone will tell me, but will not do it under oath, that there is at the front desk perhaps someone who is abusive to that patient who comes in, the veteran who perhaps is different because he has a mental health issue, and very rude. We have focused a lot on high-ranking officials within the VA and the difficulty of replacing them. What this doc tells me, I cannot get rid of that clerk, that that actually has to go here and then there.

I toured a VA and asked the director, and he goes, well, there is a report, and we counsel, and it comes back. What I really got a sense of is that it would take months, maybe even a year or two, in order to get rid of someone who is at the front desk. Again, not talking about the person padding their check by everything we have read about in the paper, but that person right there speaking to that vet who is having a hard time keeping it together, and, therefore, acts a little strangely.

To what degree is that true, and to what degree do the union contracts kind of limit the ability to discipline, replace, make it better for the veteran? I will stop there.

Dr. SHULKIN. Well, one of the things when the Secretary came in, as you know he had us all sign and agree to the I Care Principles, of which respect and customer service is right there. When we find that people are not sharing our values, my expectation is, the Secretary's expectation, is that we are going to take actions to remove people who are not following the VA values.

Then you get into due process, and we have due process, and we need to adhere to it, and it is longer than some of us want and more complex. But we are not going to let somebody be disrespectful to veterans and stay in those positions.

Senator CASSIDY. Now, let me say I have worked in a public hospital, and there are 95 percent great people struggling to make it work, and there is 5 percent that really—but that 5 percent becomes the face of the organization, and at times that one person destroys it for that patient, if you will. Believe me, I have worked in a hospital in Louisiana. I know that.

You spoke of due process. Let us assume that there is someone, as we have described, as I have been told of. I have learned to say what I have been told, not what I know, but that what I have been told of. How long would it take for that person to be dismissed?

Dr. SHULKIN. Our expectation is that if there is a behavior that is not consistent with our values, they would be removed from that position, the veteran patient position. And then we have to assign them to other work, hopefully not involving direct contact with veterans, and let the due process, you know, work its way through. But it would not be acceptable because of bureaucracy and red tape to allow a person who we know is not sharing our values to continue with a direct veteran-facing position.

Senator CASSIDY. So that person could be reassigned fairly quickly——

Dr. SHULKIN. Absolutely.

Senator CASSIDY [continuing]. As in a month or a week?

Dr. SHULKIN. Oh, no. I am talking about immediate. When somebody comes to us with a concern or allegation, it is investigated because, as you know, as you said, in a lot of these situations in my experience, you know, it is not always what you first hear the story.

Senator CASSIDY. I get that.

Dr. SHULKIN. So you have to get the facts. But if the facts confirm that this is a person who is not treating veterans the way that we believe they should be treated, then they should be removed from that position immediately, reassigned to something else while there is due process. There are certain violations that would be immediate termination, and we certainly do that as well.

Senator CASSIDY. There is an inspector general report about a fellow who actually killed a patient who is still on the job, so that is kind of what—just to say that is high profile. But just to say it seems as in in theory sometimes it takes a long time.

Dr. SHULKIN. I would like to get that specific situation from you and then follow up with you on that. That certainly is a circumstance that I would want to know about.

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

Senator KIRK. Mrs. Capito.

Senator CAPITO. Thank you, Mr. Chairman, and thank all of you. I apologize for not being able to hear the entire hearing, but we have got several going on at the same time, as Senator Murray and I have seen each other a couple of times today. So I appreciate your—and so if I repeat a little bit, please excuse me.

CHOICE PROGRAM THIRD PARTY ADMINISTRATORS

I wanted to talk about the Choice Program. We just had some veterans in our office the other day. In one instance, the veteran had an appointment with a specialist, only to find when he called that office, the entire facility did not have that type of specialist. And it was the second call that that facility had had for that type of specialist. The same veteran had another instance where he had called Health Net Choice four times to have an appointment made and did not get satisfaction. We are hearing these stories all over the place.

And I guess, what is being done from your perspective, and I am going to say are these the third-party administrators that are not filling the gaps? What are you all doing to hold the third-party administrators' feet to the fire here?

Dr. SHULKIN. Okay. I should start off by saying that the Choice Program is not working the way that any of us want it. So I am aware that you are probably not the only Senator who is getting a lot of these issues.

We are continually meeting with the third-party administrators, and not only letting them know it is our expectation that they adhere to the contract. The contract says that a routine consult needs to be scheduled in 5 days. An urgent consult needs to be scheduled in 2 days. And when they are not able to do that, we need those authorizations returned to the VA so we can use our community relationships to help the veteran.

We are not only working with them, but we are throughout the country now trying new models of delivering care, like embedding their staff alongside our staff to be able to try this. So we are doing this in Alaska and several other sites.

But the program is just simply not working the way that we intended it to work, and we are going to stick at this until we can get this working better for veterans. So we would ask if you are hearing specific veterans having issues, please let us know with their names so we can help them.

Senator CAPITO. Okay. That I will do, and I know that it just seems like there is a lot of confusion.

Dr. SHULKIN. Yes.

Senator CAPITO. Best intentions aside, it is still, as you said. And I appreciate your candor there really.

Dr. SHULKIN. One of the things that you missed, Senator, is Senator Tester had mentioned that part of this we need your help on. And Senator Tester and Senator Blumenthal and Udall just submitted a bill that helps us consolidate community care, simplify this for the veterans, simplify it for the VA. And so, this is where we could use your help because have identified where the program needs to change and what we have learned over the past year. That would help us a great deal.

VETERANS TO AGRICULTURE PROJECT

Senator CAPITO. Thank you. Thank you. One of the programs that I have been sort of interested, it is a small program, and it is growing—it is in West Virginia and growing in some other States. And it is the West Virginia Warriors and then Veterans to Agriculture Project. It seems to have met with quite some success with some of our younger veterans.

So I do know, Mr. Pummill, I do not know who would take this question. What are you doing with—in terms of encouraging veterans to transition to agriculture? Is that part of an emphasis within the VA, and how is that going?

Mr. PUMMILL. We have expanded what we encourage veterans to do when they leave military service greatly under the new transition program. It used to be, you know, pretty much your only option was use the GI bill and go to college. Now we are offering a GI bill, agriculture, entrepreneurship where they can learn how to start their own business, or technical training, technical schools, truck driving, things like that, realizing that one size does not fit all. And we are trying to find the thing that best suits that individual and lead them in the transition to that

The best success we have had, like you just said, in West Virginia is working with the State and local agencies so that when we know where the individual, which State he or she is going back to, they have somebody to link up back there with what they need to do.

OPIOID DEPENDENCE AND ALTERNATIVES

Senator CAPITO. Right. Good. And then lastly, Senator Baldwin and I have under her leadership worked on the Opioid Safety Act, which as a result for me was from a young man, Andrew White, who I believe died in his sleep, I think, as a result of a shoebox of prescriptions that had been filled—prescribed to him by the VA.

What are you doing in this area now that you have more of a directive and I think more of an area of emphasis because of what we have done here?

Dr. SHULKIN. I think as you know, and we appreciate your leadership in this, the opioid dependence crisis is really a national crisis. I was at a dinner last night with the director of the Centers for Disease Control and Prevention (CDC) who said this is the area he is most concerned about nationally. Fortunately I think VA, and thanks again to several of you who have taken the lead on this, has really understood this for several years. And we are doing really what the rest of the country should be doing. Our numbers are going down while the rest of the country is going up.

Senator CAPITO. In terms of prescribing?

Dr. SHULKIN. In terms of number of veterans on opioids and finding alternatives for them. So we have instituted mandatory training. We have instituted mandatory reporting into all the States that require the drug monitoring programs. We use a stepped management approach. We are encouraging providers with what we call academic detailing where we train them to use other non-medication approaches to pain management, like integrative therapies. We have adopted not only the CDC guidelines, but work with DOD on DOD–VA guidelines for opioid management.

So we are making progress. We need to do much, much more, but our numbers are coming down, and I think we are headed in the right direction. And we are going to stick at this until we can actually get to this to the very minimum number of patients who need to be on opioids.

Senator CAPITO. Thank you.

Senator KIRK. Mrs. Murray.

Senator MURRAY. Thank you, Mr. Chairman.

CAREGIVERS PROGRAM

Mr. Secretary, Dr. Shulkin, I am really pleased to see that you are requesting a significant increase for the Caregivers Program, which, as you know, gives veterans more control over their own healthcare and supports the loved ones who sacrifice their life, their own time, their health, their energy to provide that care. This is really a personal issue for me. My mother cared for my father, who was a World War II veteran, after he developed MS, and I know the impacts to these families.

So now as demands on the VA continues to rise, I strongly believe that the Caregivers Program is really a key to helping VA

carry out its duty to provide accessible high-quality care. And to make this program work, the VA is continuing to increase the number of Caregiver support coordinators. Considering the expected increase in Caregivers, and if we can finally pass the legislation to expand the Caregivers Program to all veterans, I am concerned we will need more.

And my question for you today is, is the workload for individual Caregiver support coordinators going down, or do you need more staff to keep up with the demand?

Dr. SHULKIN. Yeah, it is a great question. This is—Senator Murray, I know you are passionate on this, and I thank you for that. This is an area that VA is so different than the private sector in recognizing this and supporting Caregivers. Interestingly, the data is coming out now to say this is a cost-effective way to manage healthcare costs.

Senator MURRAY. I am not surprised, but I am glad there is data.

Dr. SHULKIN. Without Caregivers, these patients end up back in the institutions, and they do not want to be there, and it is very expensive to keep them there. So we are expanding this. And you are correct, we do need to keep up with the caseload because Caregivers need support. Elizabeth Dole, Secretary Dole, is very articulate about this, and has actually been working with us to help us support our Caregivers.

So the workload is going up, but we are so pleased to be able to expand this program with this budget request.

Senator MURRAY. Okay, great. Secondly, I have heard from veterans in my home State of Washington who are frustrated always about waiting months or even longer to get answers to questions about benefits and care. So I am really pleased to see that you are requesting significantly more funding for both the Health and Benefits Administration. That is really essential to providing good customer service.

But I am concerned again whether that will be enough and whether the Department is managing its money appropriately. The crisis that we faced last year when the VA threatened to shut down the healthcare system and nearly ran out of money cannot be repeated. So the funding that we provide in 2017 and 2018 has to account for major increasing demands on the VA, including providing, as you know, treatment for hepatitis C, increasing demand for care both in the VA and in the community, and the costs associated with the VA's new proposal to consolidate care in the community.

FORECAST FOR BENEFITS DEMAND

So in light of all of those pressures, how do you anticipate demand for care benefits growing over the next 2 years?

Mr. MANKER. So we—as look at the caseload, what we see is—in 2017 and 2018 we see an increase in the request for claims. And the second and third order of effective claims is as folks file claims that we—they go over to the Health Administration for care there.

Senator MURRAY. So you see increasing demand.

Mr. MANKER. We do.

Senator MURRAY. And does this budget accommodate that?

Mr. MANKER. I know from the VBA perspective it does, yes.

Senator MURRAY. Okay, because that is what we hear constantly from our constituents when we do not have enough people out there to process. So we are going to be looking at this closely.

CAREGIVER TRACKING SYSTEM

Let me go back again, Secretary Shulkin, to you. The budget request actually attributes most of the increase in the Caregivers Program to more Caregivers receiving stipends. But as you know, one of the GAO recommendations for the Caregiver Program is to create a new IT system to administer the program and to make it more efficient. This system will be really essential as we come closer to expanding the Caregiver Program. I wanted to ask you, is there enough funding in your request for the new Caregiver Tracking System, and will it be ready on time?

Dr. SHULKIN. Senator, that is something that I going to ask if I can back to you on because that is—I am going to need to work with counsel and the OI&T on that, and make sure that there is the appropriate resources to do that. And if I could, I would get back to you.

Senator MURRAY. Okay. If you could answer me for the record.

Dr. SHULKIN. Yes.

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

Senator MURRAY. And that is a really important part of making this work effectively.

Dr. SHULKIN. Yes.

Senator MURRAY. So we need to have that ready, on time, and at capacity.

Dr. SHULKIN. Absolutely.

Senator MURRAY. Thank you very much, and I will submit the rest for my record—questions for the record.

Senator KIRK. Now, the Senator from King Cove, Alaska.

VA HEALTHCARE SYSTEM IN ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. Dr. Shulkin, it is has been about a year since you last visited my office. I do appreciate you coming to the State last summer, but I regret to tell you that we have seen very little follow up on the state of the VA health system in Alaska. So let me tell you where I think we are right now in Alaska, and this is not necessarily through my eyes. This is through the members of the Veterans Service Organizations that have been flooding my office in the past several weeks.

Before you and Secretary McDonald came to your jobs, we had a VA system—a healthcare system that worked up in the State. Our vets were seen in a timely fashion. Those that had conditions that could not be handled by the VA were seen in the community at fee-based care providers. We had good partnerships with our community health centers and with the native healthcare system to back up.

But the vets who have been coming in, again, over these past weeks and when I have been up home, they are telling me that the current leadership team at the VA took a system that was working well in our State and went about dismantling it. And a couple of

illustrations here with regards to the Choice Act that did not require the VA abandon its legacy fee-based programs. VA reads it otherwise, and canceled fee-based appointments. These vets were forced to deal with the dysfunctional TriWest referral system. They still are. Veterans who have been forced to use the Choice Act then discovered that VA did not pay for their care as they had done previously. And now what we are getting—the letters that I am getting from vets are saying my bills are being sent to collection agencies when the VA does not pay.

We do not have very deep representation with medical specialists, but specialists who were willing to take the Choice card are now telling me they do not want to have anything to do with the hassle, nothing at all. So we have got a loss there.

We had a great and innovative director at Anchorage VA Healthcare System. Not there anymore. That position has still not been filled. There is still no full-time physician at the Wasilla CBOC (Community-based Outpatient Clinic). The VA is able to find some providers who may consider relocation, but then they pull out after the relocation promises that have been made by the VA recruiters are withdrawn because they never should have been made. And, again, we are not seeing VA senior leadership coming and saying we have got—we are willing to work with you. We are going to solve these problems.

So the question to you, Dr. Shulkin, is how would you assess—I have given you my assessment and the assessment of so many of the veterans who are coming to my office. But how would you assess the state of the Alaska healthcare system for the VA in my State right now? What needs to be done to restore the access and the quality of care that our veterans had, but they no longer are experiencing?

Dr. SHULKIN. Okay. Well, you have mentioned a lot, Senator, and so let me try to briefly just tell how I look at this. I think that you have identified several things. So pre-Choice I think Alaska had a very innovative system that was working well.

Senator MURKOWSKI. It took a long time, but we got there.

Dr. SHULKIN. No question about that. Choice was implemented and system was changed. And I think that some of the situation you are talking about was dated a while ago where essentially we were not using fee-based programs. We were not using community care programs, and we were only using Choice. That situation has now changed in Alaska where after our visits up there, we are working very closely with the Indian Health Service, we are working with the South Central Foundation, we are working with the DOD facilities there where I think that you are not seeing some of the problems that had existed before.

The Choice Program still continues to be a challenge, and that is why we have worked closely with TriWest to actually embed TriWest employees in with our VA people, and there are three embedded TriWest employees today in the Anchorage facility. It still is somewhat problematic, and that is why we are continuing to ask for a contract modification so that VA can take over the scheduling of those patients, very similar to what you had before. And we are waiting for that contract modification to be approved.

So Alaska is—was a system that, frankly, was a great model for the country. It went through some tough times. We are trying to get that back. I think that part of what we are trying to do with this new legislation that Senator Tester has taken the lead on is to bring back the customer service pieces, what you had in Alaska back to the VA. And we know that we have a lot of work to do.

Senator MURKOWSKI. Well, and I am sure you can appreciate the frustration of the many veterans who for years had struggled with a system that did not work, and then through the good work of cooperation and collaboration between IHS, community health centers, we kind of built this system.

Dr. SHULKIN. Yes.

Senator MURKOWSKI. And we were providing the care that our veterans deserved and expected, and we wanted to be able to provide, and it worked throughout agencies. And then we come in and we have got this top down approach, and we are starting all over. And your term "somewhat problematic"—"somewhat problematic"—is not what I am hearing from our veterans. They are saying it is fouled up! It is screwed up. It is a mess. And it is unacceptable. It is unacceptable because we know how to correct it because we corrected it. And then you come in and you create chaos.

So we had asked in the fiscal year 2016 approps bill that a report be submitted on the current status of VA healthcare in Alaska. We are waiting for a status of that report. You know, you suggest that some of the information that I have here is dated. It is not—it is not dated, not based on the experience of veterans who are trying to access their healthcare now, who are getting these bills from collection agencies now. This is not based on some things that were happening a year ago, 6 months ago.

So I am—we will have Secretary McDonald here before the subcommittee, and I certainly intend to ask him what corrective actions plans you have regarding all of these issues that I have outlined. In the interim, it might be helpful certainly for you all and my staff to meet to have a more comprehensive conversation about the quality and the access because what is happening now is the—is the quality of care, the access to care has been compromised for these Alaskan veterans. And there will be no compromise. There cannot be no compromise for these healthcare benefits.

And, again, I think part of the frustration that we have is we have come so far only to see it turned over literally within the course of a couple months. And you cannot pull the rug out from underneath those who have earned these healthcare benefits, and that is exactly what your system has done.

And we thought that the visits to Alaska were going to materialize in some changes that our veterans could see, but I am pressing each and every one of them. I am saying you got to be honest with me because the information that we get from you is the most telling. And what they are telling me is it has not been fixed, it has not been corrected, and they are not doing enough.

There is no compromise on what our veterans have earned, so know that we are going to keep working at it. And it would be great if we could set up some time to sit down on that.

Dr. SHULKIN. Senator, I just want to mention a few things. First of all, I appreciate where you are coming from. I heard it personally——

Senator MURKOWSKI. I know you did.

Dr. SHULKIN [continuing]. In Fairbanks, and Anchorage, and the Kenai Peninsula. And these were packed houses of people saying exactly what you are saying.

But I just do want to say a couple of things that I hope will be helpful. First of all, this was the Choice Program. This was Congress' program that we are trying to make work, and we understand that it is not working well, and that is why we are working with you, and we look for your support to make the changes that we need to make.

But currently, 96 percent of all appointments are scheduled within 30 days in Alaska. We have 120 outstanding consults more than 30 days that are urgent consults. They are all out in the Choice Program. They are all scheduled, but that is too long, and that is what we are working with TriWest to fix to make sure that we can improve that.

In terms of putting veterans in line with their own credit, unacceptable. We do not want that happening. We have established a toll free hotline now that is 1 (877) 881–7618 that veterans should call if they are being hounded by creditors so we can intervene on their behalf because we do not want them put in that position. And I know that is happening for people in Alaska and across the country, and we are going to—we are going to help them with that. Thank you.

Senator MURKOWSKI. Well, I look forward to our sit down. Thank you, Mr. Chairman.

Senator KIRK. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

ADMINISTRATIVE INVESTIGATION BOARD ON MILWAUKEE DOMICILIARY

Dr. Shulkin, as a result of concerns that I reported and shared with the VA, the VA convened an Administrative Investigation Board in October of last year to review many allegations regarding improprieties at the Milwaukee domiciliary. One conclusion reached by the Administrative Investigation Board, otherwise known as AIB, was that the domiciliary environment was not safe and secure.

An issue raised to corroborate this assertion was that the noninspection of veterans' belongings. Veterans were found to have alcohol, box cutters, and straight razors. More alarming, during the time of that review, while the AIB members were there, a veteran tried to commit suicide.

Mr. Chairman, I would like to insert in the record a news article that appeared last night on CBS 58 in Milwaukee that has to do with the story that I am about to tell.

Senator KIRK. So ordered.

Senator BALDWIN. Thank you.

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

Senator BALDWIN. In my view, this puts a finer point on the need to inspect what veterans and visitors are bringing into the domiciliary. Last year, a young veteran, a resident of the VA domiciliary in Milwaukee, he was recently out of a rehab program, overdosed on heroin, and was found dead in his room at the facility. My understanding is that he was able to bring in needles into the facility and potentially the drugs that caused that overdose. This is someone who came to the VA for help.

Dr. Shulkin, I am very concerned about the whole domiciliary program. At my request, the inspector general's office is reviewing the issues surrounding the death of this young veteran. But I think we need to go a step further and reassess the program to determine whether security measures nationwide are appropriate, and whether domiciliaries are the right place for veterans such as ones who have attempted suicide or who have overdosed. It seems to me that a facility like this has lax oversight of its resident population, and may not be the best place for these veterans.

So can you speak today to the security of VA domiciliaries, and whether you are willing to take a hard look at the appropriateness of the program for veterans who may need greater supervision?

Dr. SHULKIN. Yeah. Senator, what we are talking about is the best approach towards this issue that, frankly, is a national epidemic we are seeing all over the country on substance abuse. And veterans are a particular risk for substance abuse.

And so, the domiciliary programs are part of our approach, and I do think, and I am open to taking a look at better ways of doing this and better ways of trying to address both treatment and prevention of substance abuse. And I wish I could tell you that we have found the magic bullet for this, but we need to be trying harder.

On the issue of security, I will tell you this is a problem for hospitals everywhere. I have struggled with this throughout my career. It is simply is not possible to search every patient and every visitor and ensuring what they are bringing in does not contain drugs or paraphernalia like syringes. It just simply would not be effective. You would have to have essentially what amounts to what they do in prisons, which we do not want our facilities to be like that.

So what we do is we need to set up rules about behaviors that we expect and what happens and consequences if you break those rules, being discharged from the programs. Do we need to look at new ways to be able to make sure these are safer places? Absolutely we need to. But I do not want to give the expectation that by searching people we are going to be able to prevent this completely.

Senator BALDWIN. Okay. Just in follow up and based on your answer, there is absolutely a range of activities and procedures that could be put into place to increase safety and security beyond the search issue. I will note that I have heard that the AIB members who were present on site to conduct their investigation were able to gain access the facility with no one checking them at the door or even, you know, they were already wandering about. And so, that obviously suggests a lax set of protocols.

I would appreciate it if you can commit to reporting back to this subcommittee on at least an initial review of the use of these domiciliaries, and the security, and supervision levels, and safety. This is a big concern.

[The information follows:]

Context of Inquiry: Will VA commit to reviewing the domiciliary program, including the security and safety protocols and the appropriateness of participation of veterans who may require greater supervision? When can we expect the results of that review? [reference Dr. Shulkin's testimony that he is "open to taking a look at better ways of doing this." And "Do we need to look at new ways to be able to make sure these were safer places? Absolutely, we need to."]

Response: VHA Domiciliary Care programs are safe, effective and an appropriate level of care for Veterans with mental health and substance use disorders when appropriately operated in conformance with national policy. VHA will continue to closely monitor domiciliary safety and security and look for opportunities to improve Veteran care. One Veteran death is too many and every effort will continue to support the medical centers in providing a safe and secure environment focused on recovery. Veterans admitted to the residential treatment programs are assessed as needing increased supervision and support for symptom reduction and engagement in recovery and for whom outpatient care has not been effective. VHA's residential treatment programs provide vital services in the mental health continuum of care which includes general outpatient, intensive outpatient, residential and acute inpatient. VHA fully recognizes the increased risk in serving Veterans with mental health and substance use disorders in a residential level of care.

At the end of fiscal year 2015, VHA operated 244 Mental Health Residential Rehabilitation Treatment Programs (MHRRTP) with 8,148 beds at 113 VA Medical Centers. During fiscal year 2015, there were over 37,500 admissions to domiciliary care with 87 percent of the Veterans admitted having a Substance Use Disorder (SUD) diagnosis. Over 15,000 Veterans were provided residential specialty care specifically to treat their SUD. In fiscal year 2015, there were over 2 million patient bed days of care provided in VHA Domiciliary programs. During this period, there were 13 reported Veteran overdoses resulting in four overdose deaths. The mortality rate for Veterans during their residential stay during fiscal year 2014 was 0.06 percent and has decreased by 56.8 percent since 2004.

VHA is currently revising and updating the VHA MHRRTP Handbook, 1162.02. The revisions will include updates to safety and security policy and procedures based on lessons learned since the Handbook was published in 2010. VHA recently updated guidance clarifying expectations for contraband detection and prevention in Domiciliary programs. This guidance has been shared with key stakeholders and was recently shared with the field. Concepts discussed in the guidance document have been routine topics of conversation with the field through regular monthly calls and at the National MHRRTP Managers conference on May 3–5, 2016. A significant step forward in the safety and supervision of VHA's residential care is the current development of a Nursing Model that will guide the provision of 24/7 nursing services in Domiciliary programs based on the Veteran's needs. This collaborative effort between the Office of Nursing Service and Mental Health Services is currently being piloted at ten Domiciliary locations and when completed will be implemented at all locations. This initiative is expected to result in improved patient care and the supervision of the residential units.

NALOXONE KITS AS A HIGH PRIORITY

Senator BALDWIN. I want to just briefly pivot to the related issue of over reliance on opioids, and I appreciated Senator Moore Capito talking about the bill we have worked jointly together named in honor of a marine veteran in Wisconsin, Jason Simcakoski, who died at a VA hospital in Tomah.

You may recall that the inspector general report released last August detailing his death from mixed drug toxicity revealed that antidotes to overdose, like naloxone and flumazenil, were not available on the emergency crash carts that were brought to Jason's room, and that a facility staff member was tasked with securing an

antidote from the urgent care clinic, and then it arrived in his room some 33 minutes later after he was found unresponsive.

So I understand that the availability of naloxone and related antidotes are tremendously important. They can and do save lives. That leads me to the VA's legislative proposal to eliminate co-pay requirements for naloxone kits it distributes to high-risk veterans. Since its implementation more than 2 years ago, they have been extensively distributed, and lives have been saved.

But I also know, and you know, that the recently signed Omnibus Appropriations Bill and the Jason Simcakoski Memorial Act that I referred to would expand the VA's overdose education and naloxone distribution program to ensure that every VA medical facility and pharmacy is equipped with opioid receptor antagonists such as naloxone.

I want you to please to speak to why providing these kits free of charge is such a high priority.

Dr. SHULKIN. Yes. Well, I think you have said it very well, Senator, which is that in the case of overdose, these are lifesaving drugs. I have personally used them, and people go from being essentially unconscious to waking up and talking to you in a matter of seconds. And so, if you do not take the right actions, they stop breathing, and obviously they can die.

So I could not agree with you more. Having these available, much like years ago we did with the automatic implantable defibrillators that you see now in waiting rooms, and airports, and restaurants. VA has been distributing these kits out to community partners in various areas. We have been doing it by the thousands and successfully. I think that getting more of them out will be helpful.

Last year we prescribed 18,000 prescriptions for naloxone. I think you mentioned the issue of co-pays. Fifty percent of them required a co-pay. Eight dollars is our average co-pay. So anything that we can do to help eliminate barriers to the use of these drugs I think would be important, and education is a primary target of ours as well.

Senator BALDWIN. Thank you. And, Mr. Chairman and Ranking Member, I will submit some additional questions for the record. I thank you for the time.

HEPATITIS C DRUG TREATMENT

Senator KIRK. With your indulgence, I will go with a second round here. Let me get you on the record about hepatitis C. Last year the subcommittee appropriated $1.5 billion for treatment of hepatitis C. We have also appropriated another $1.5 billion for advance appropriations in 2017 for the treatment of hepatitis C, which should be a good news story. There are dramatically different figures put out by you and the Department about how many new patients starts will be achieved in this fiscal year on hepatitis C.

I would like to see how many do you project will be started in fiscal year 2016.

Dr. SHULKIN. Yes. Well, first of all, I could not agree more. We thank you for your leadership in providing this to veterans. This is one of those miracle drugs that have come through——

Senator KIRK. I would say this is a chance for us to have a hepatitis C free veteran population.

Dr. SHULKIN. Yes, absolutely.

Senator KIRK. Probably the best legacy for the President on his way out of office.

Dr. SHULKIN. Well, with a 95 percent cure rate, I am not sure that you can do that many things this well, so thank you again for that support.

Let me go over the numbers. There should not be any confusion about this. VA estimates, using its databases, that we have 120,000 veterans who have hepatitis C. You can measure hepatitis C in the blood. We were originally given the $1.5 billion and, given our pricing for hepatitis C drugs, able to treat this year 35,000 veterans. However, the price of the drug has dropped.

Senator KIRK. They have to go through a course as I remember, and for those 35,000 new starts——

Dr. SHULKIN. It's a series of treatments, yes.

Senator KIRK [continuing]. We would then expect a 97-percent success rate with the new starts.

Dr. SHULKIN. I think—I think that is pretty good. But the reason why there may be some confusion, we have had additional good news, and that is the pricing on this drug has dropped. That means we are going to be able to treat more veterans this year. So instead of 35,000, we potentially—potentially—could treat 70,000. That means that if you were able to treat 70,000 veterans and you only have 120,000, we could actually eliminate or cure those that have hepatitis C today because new veterans will enter the system——

Senator KIRK. Right.

Dr. SHULKIN [continuing]. In approximately 2 years. What a—what a great story. This would be a miracle and, frankly, a great thing to do for veterans.

The reason why my staff may be using a different number than the 70,000 is that this is the potential. To get 70,000 veterans through the VA to screen them, to make sure they are appropriate to put them through all these treatments, that would require us right now given where we are in fiscal year 2016 already, we have treated 9,100 patients this year in fiscal year 2016, to do 2,000 starts per week.

We have once done that in a week in September of 2015 when we went through extraordinary efforts right before the budget year ended to get as many veterans in to spend last year's $1.5 billion. But maintaining 2,000 veterans a week for the rest of the year, frankly is not going to be practical given our current resources.

So what we are looking to do is to ask for some flexibility in the $1.5 billion, 5 percent of it, to actually increase our staffing in these clinics so we can bring through 2,000 veterans a week. So if we can actually staff up a tiny bit in these hepatology clinics, these hepatitis C clinics, that would be our goal in 2 years to essentially eliminate this from the VA system.

It is going to take an effort operationally to catch up. Right now we are very comfortable that our staffing levels are doing about 1,300 starts a week, okay? That is really our capacity given our current staffing that we could sustain. That would get us part way towards that number. It would get us, you know, in the 40- to

50,000 a year, and, frankly, we are going to do everything we can to treat every veteran with hepatitis C.

OVER PRESCRIPTION OF OPIOIDS

Senator KIRK. Good. Could I divert from you to what I have noticed is what I would call a VA way of practicing medicine. This has happened in my own family where it seems like—you already described the over prescription and ways to deal with opioids. Last night the Senate passed the Kirk amendment that would bring the VA into the reporting system that we created under the legislation to make sure that we are going downward on over prescription.

In my experience, the over prescription has been Xanax and Ambien, too much of that where you develop a real dependency. Is there a way that we can make sure that with psychotropic drugs that we are doing less and less and less of that just to get the patient out of the door?

Dr. SHULKIN. Yeah, actually VA does have measures on this. I do not have the statistics off the top of my head, but we not only know how many patients are on benzodiazepines, but actually the combination between benzodiazepines and opioids. And we have targeted that as a high-risk sort of high-alert area.

Senator KIRK. Just see if it is part of socialized medicine to get the patient quickly out the door to give them Xanax and Ambien in nearly unlimited quantities. I would note that Senator Baldwin has talked about the Tomah facility——

Dr. SHULKIN. Yes.

Senator KIRK [continuing]. Which was called the candy factory because so much was over prescribed there.

Dr. SHULKIN. Yes. Yes. So I think we recognize this is a challenge. That is why we are doing so much provider and mandatory training on this, something that I think that we are looking to make significant progress on. Thank you.

Senator KIRK. Mr. Tester, any final words?

VHA 2018 ADVANCE REQUEST

Senator TESTER. I do. Thank you, Mr. Chairman. I want to drill down a little bit on the numbers, particularly with the 2018 advance request. I do not see any of the annualized costs for the new doctors and nurses that are going to be hired with the Choice Act funding. Now, you are going to get another bite at the apple next year as far as fiscal year 2018 goes. But does this not leave a huge hole in your future budget?

Dr. SHULKIN. It does. I think you are correct. There is no continued funding in fiscal year 2018 for these new hires. And I would also add there are some other components, such as our graduate medical education residents. The 5,000 residents that were granted, they also did not continue. And so, and there are actually some other components. But I am going to ask the expert on this to just clarify exactly what you are asking about, Senator.

Senator TESTER. Yes.

Mr. YOW. Yes, sir. We would need about $1.3 billion to continue the hires in fiscal year 2018.

Senator TESTER. Yeah.

Mr. YOW. We would need about $280 million to continue leases that were funded with VACCA section 801 funding, and we need about $90 million to continue the residents that were hired under section 301 of VACCA.

Senator TESTER. Okay. I got it, and I appreciate your frankness. $1.3 billion, $280 million, $90 million for the residency. This is going to leave a hell of a hole, guys. I mean, why are we putting an emphasis on getting healthcare providers across the system, urban and rural areas. We are going to be laying these folks off.

Dr. SHULKIN. Well, the advance appropriation is to be able to supply us with a stable amount of money going forward, but there has to be a second step, as you mentioned, Senator, for us to identify what our actual needs are. Now, with the new Veterans Choice Program, what we are trying to understand is what those exact numbers are so we can come back and talk about that.

VA AND DOD JOINT ELECTRONIC HEALTH RECORD

Senator TESTER. Okay. I gotcha, and I just want to tell you that from my perspective, if you need $1.3 billion for the new hires that we are hiring and it is not in the budget for 2018, we are not doing our job, I will just tell you that. I mean, it becomes a problem. And the worst thing that could happen, and by the way, it would hurt for recruitment, is hire these folks and then not keep them around. I want to talk about IT for a second, but we really do need to get that fixed if we could.

The IT, I mean, we have included language in the omnibus requiring the VA to develop and submit to this subcommittee a detailed plan on how to replace or fix the IT. I know you do not lead the IT team over at VA, by the way.

Dr. SHULKIN. No, I do not.

Senator TESTER. But I do know that you have probably been involved in these discussions.

Dr. SHULKIN. Yes.

Senator TESTER. Why is it taking so long to fix this system?

Dr. SHULKIN. That is one that I would be glad to defer to Laverne Council, who ably leads our IT Department. I have a great deal of confidence in her. She has gone in like you would want with her private sector background, and really challenged all of the assumptions that frankly have led to an underperforming part of the organization. And so, Laverne, I am sure when we come back to talk to you March 10th or 11th—I forget the specific day—would be glad to address that in a very clear way.

Senator TESTER. That would be good because, I mean, I think it has been 10 years ago——

Senator KIRK. Remind him we are going to do a hearing on the joint records April 14th——

Dr. SHULKIN. Okay.

Senator KIRK [continuing]. And would want your best possible details on that for the subcommittee.

Dr. SHULKIN. Absolutely. We will be prepared.

Senator KIRK. I have been holding back as prerogative as chairman to tell you what my IT program would be to make sure that we would require all narratives in the Microsoft world and all doc-

uments in .jpg to make sure there was complete usability for everybody in the industry.

Dr. SHULKIN. Okay.

Senator KIRK. And make sure that we do not have a separate beltway bandit code. And when I talked about this with Secretary Shinseki, wanting to make sure that everything was open code based on the success that Motorola has had with the Android system when they made Android all open code, and got 70,000 apps to that system. My hope is eventually if we take 25, 27 million patients in DOD and VA with an open code system will establish the medical records technologies, undeniably American. And an entire industry will always—worldwide will be here. And that is my hope that we do not let an individual beltway bandit create their own code.

Dr. SHULKIN. Okay. Well, thank you. Thank you for giving us a little insight as to what your approach is on that. Thank you.

Senator TESTER. So when the hearing comes around, you said on April 14th? Is that correct?

Senator KIRK. April 14th, right.

Senator TESTER. April 14th, it would be great to know where we are as far as the status for replacing or modernizing that system. It would be great to know what the cost estimates are for that replacement.

Dr. SHULKIN. Absolutely.

Senator TESTER. So that it is. I just want to thank you all for being here. It is a bit of mental gymnastics for you guys, and I appreciate your professionalism, and I appreciate your honesty. And I look forward to working with you as I know others on this subcommittee do to making sure that we meet the needs of our veterans. Thank you.

Dr. SHULKIN. Thank you.

Senator KIRK. Let us—we have beat you up enough here—close. I want to thank our witnesses, especially my partner, Senator Tester.

And the record will be open until the close of business next week, Thursday, so that members can submit questions for the record.

SUBCOMMITTEE RECESS

Senator KIRK. The next hearing of the subcommittee will be on Thursday, March 10.

Dr. SHULKIN. That is better than 1:00 a.m.

Senator KIRK. Better than 1:00 a.m.

Dr. SHULKIN. Yeah. Yeah.

Senator TESTER. Thank you, Mr. Chairman.

Dr. SHULKIN. Thank you.

Senator KIRK. And we will stand adjourned.

Senator TESTER. Thanks, Kirk.

[Whereupon, at 12:34 p.m., Thursday, March 3, the subcommittee was recessed, to reconvene Thursday, March 10, at a time subject to the call of the Chair.]

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 nonrating 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.

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

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

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

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

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

We continue to listen, learn, and grow.

VA'S AGENCY PRIORITY GOALS

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

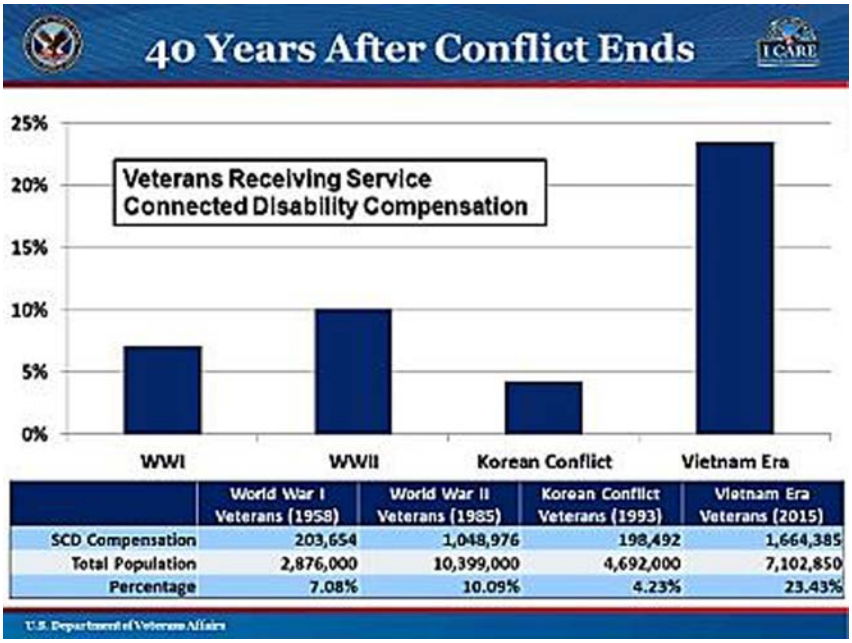
RISING DEMAND FOR VA CARE AND BENEFITS

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

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

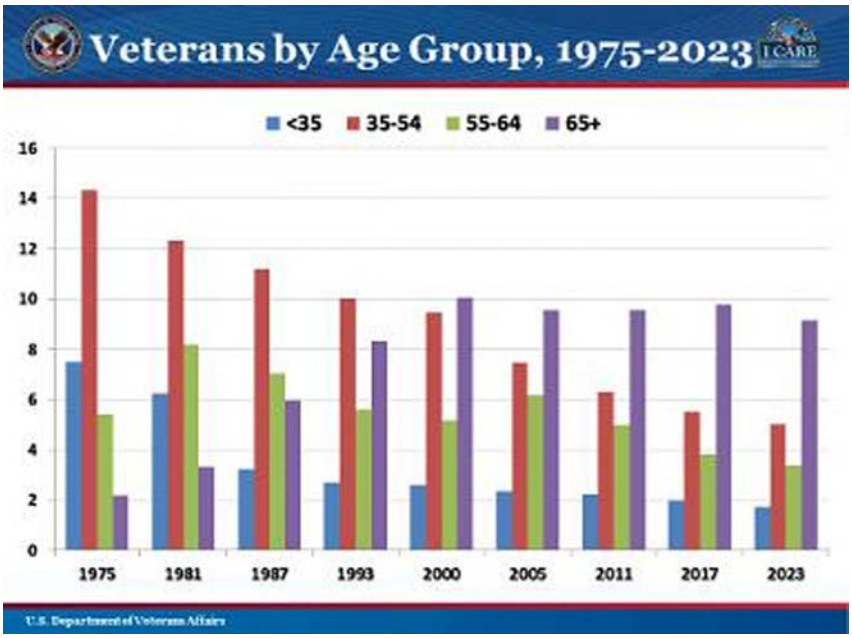
Despite these extraordinary measures to increase capacity, VA was unable to absorb veterans' increasing demand for healthcare. The number of veterans waiting for appointments more than 30 days rose by about 50 percent, to roughly 450,000 between 2014 and 2015, so we are aggressively working on innovative 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.



	World War I Veterans (1958)	World War II Veterans (1985)	Korean Conflict Veterans (1993)	Vietnam Era Veterans (2015)
SCD Compensation	203,654	1,048,976	198,492	1,664,385
Total Population	2,876,000	10,399,000	4,692,000	7,102,850
Percentage	7.08%	10.09%	4.23%	23.43%

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.



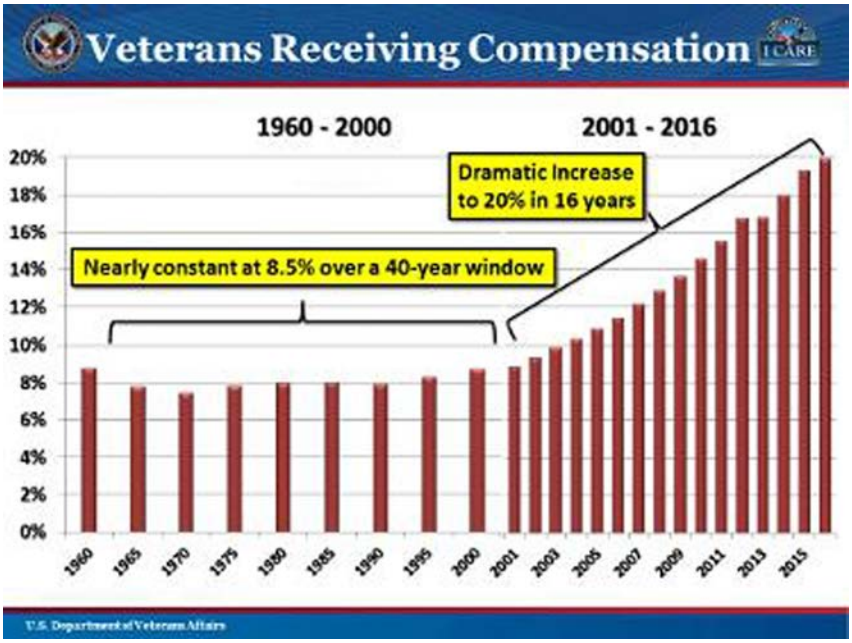
Compared to fiscal year 2009, the number of patients is projected to increase by 22 percent by fiscal year 2017. And, as veterans see the results of VA's trans-

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.

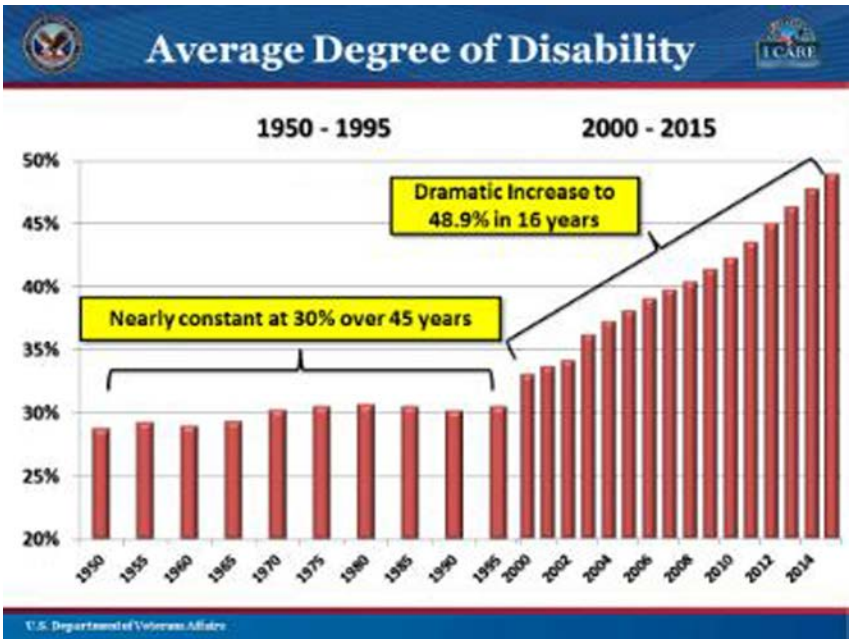
Veterans' healthcare and benefit requirements continue to increase decades after conflicts end, and this fact is a fundamental, long-term challenge for VA. Forty years after the Vietnam war ended, the number of Vietnam era veterans receiving disability compensation has not yet peaked. VA anticipates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



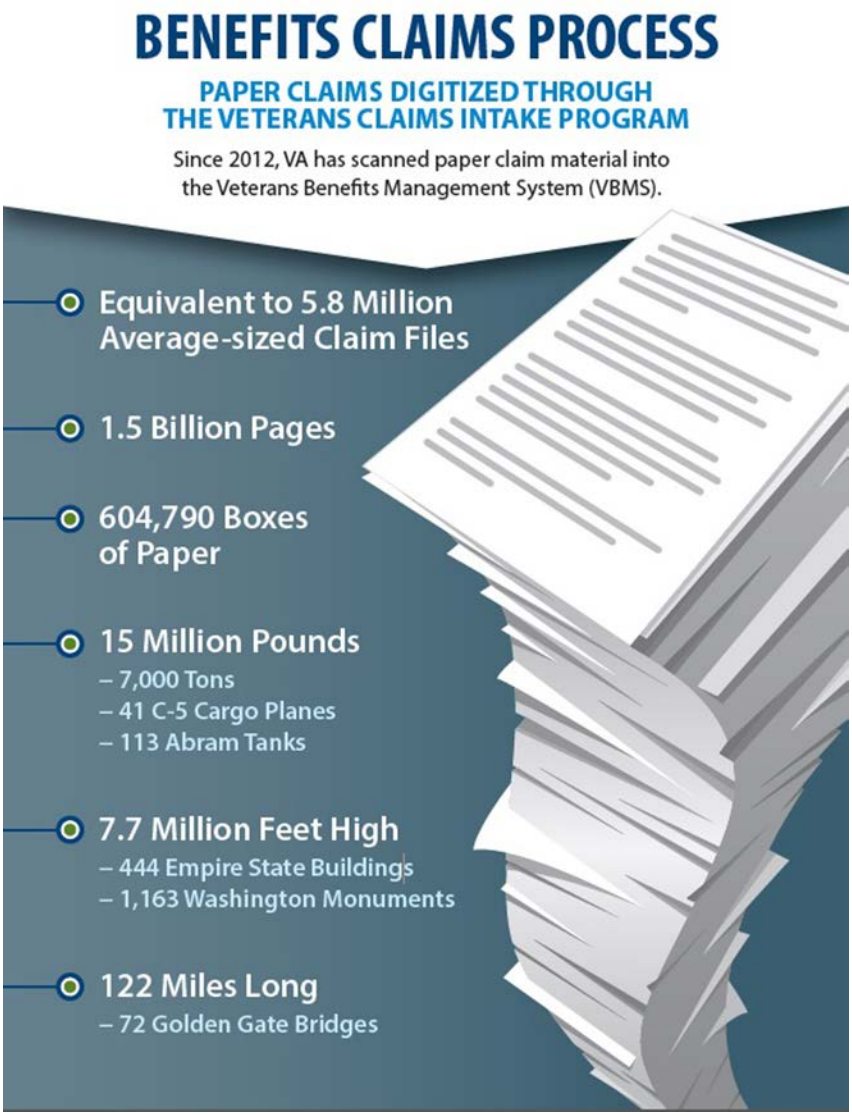
The increase in veterans receiving compensation is accompanied by a significant increase in the average degree of disability granted to veterans for disability compensation. For 45 years, from 1950 to 1995, the average degree of disability held steady at 30 percent. But, since 2000, the average degree 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.



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.

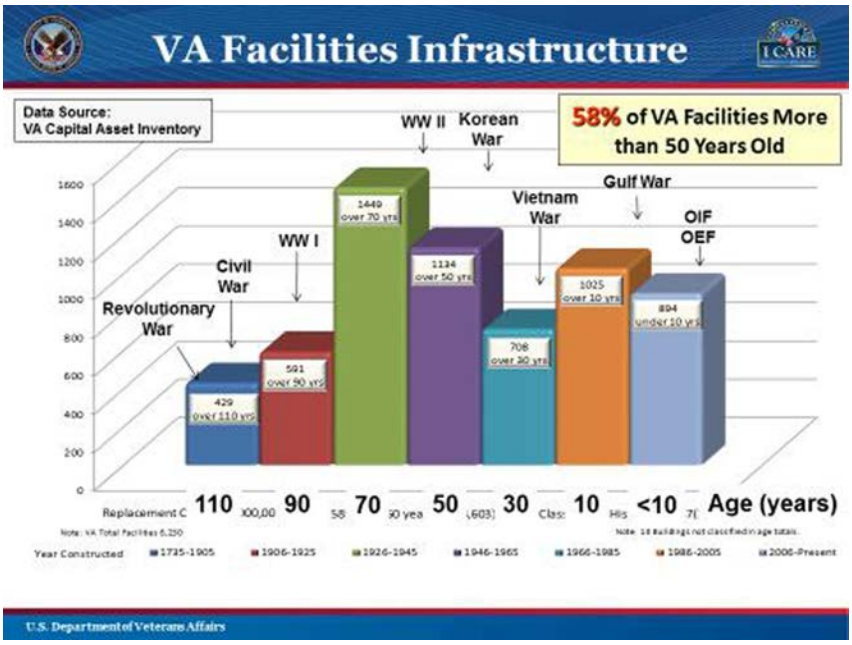
In fiscal year 2015, VBA deployed its innovative Centralized Mail Initiative to 56 regional offices (ROs) and one pension management center (PMC). Centralized Mail reroutes inbound compensation and pension claims-related mail directly to Claims and Evidence Intake Centers at document conversion services 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.

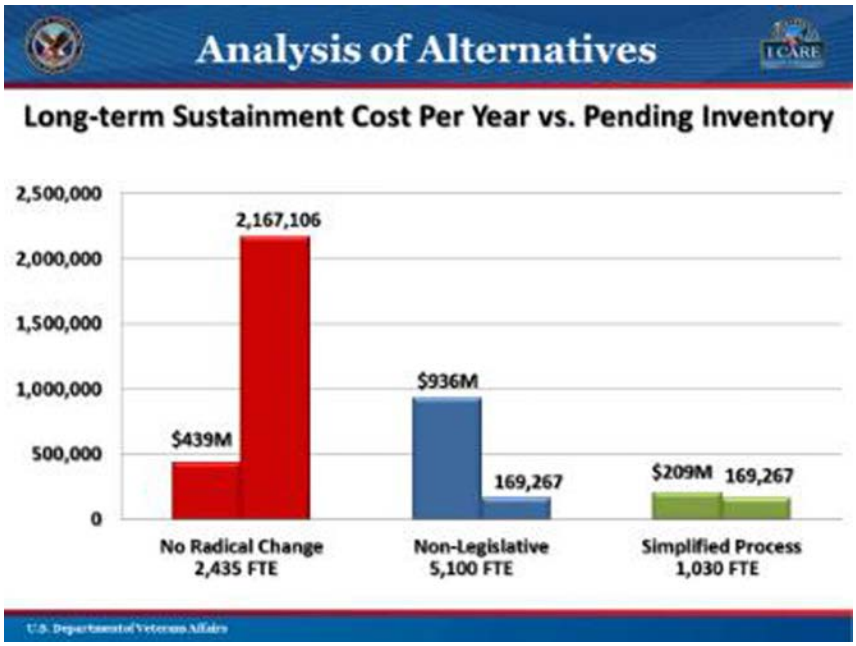
The budget requests the following advance appropriations amounts for 2018: $90.1 billion for compensation and pensions, $13.7 billion for readjustment benefits, and $107.9 million for insurance and indemnities. VA will continue to closely monitor workload and monthly expenditures in these programs and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

THE SIMPLIFIED APPEALS INITIATIVE

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

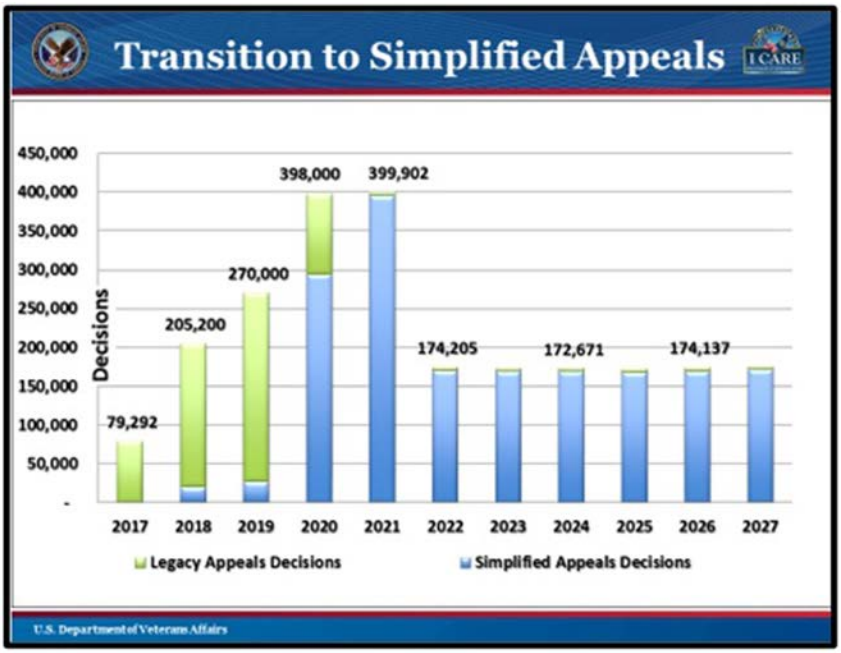
Under current law, the VA appeals framework is complex, ineffective, confusing, and understandably frustrating for veterans who wait much too long for final resolution of their appeal. The current appeals system has no defined endpoint, and multiple steps are set in statute. The system requires continuous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

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



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

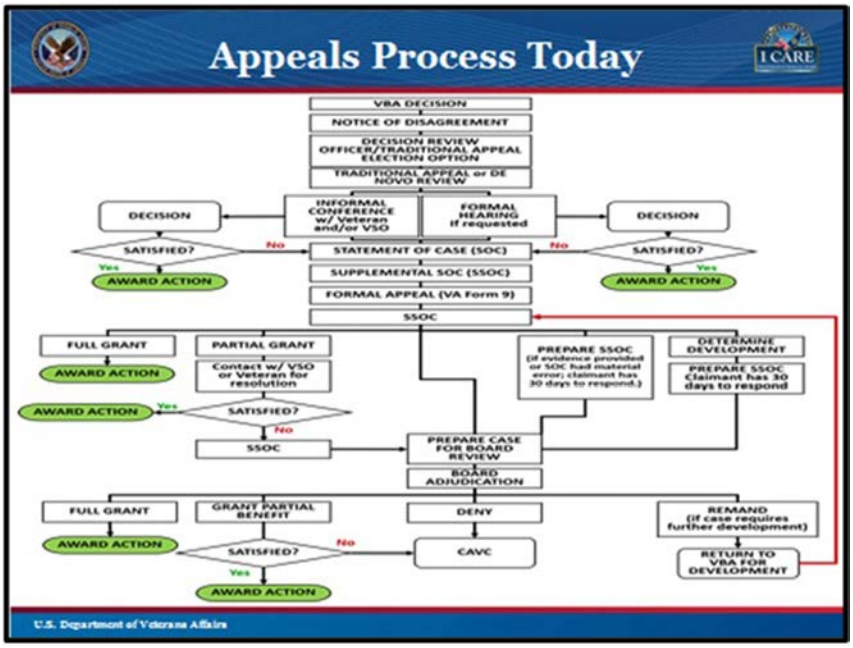
The 2017 budget requests $156.1 million and 922 FTE for the Board, an increase of $46.2 million and 242 FTE above the fiscal year 2016 enacted level. This is a down-payment on a long-term, sustainable plan to provide the best services to veterans. This policy option also represents the best value to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

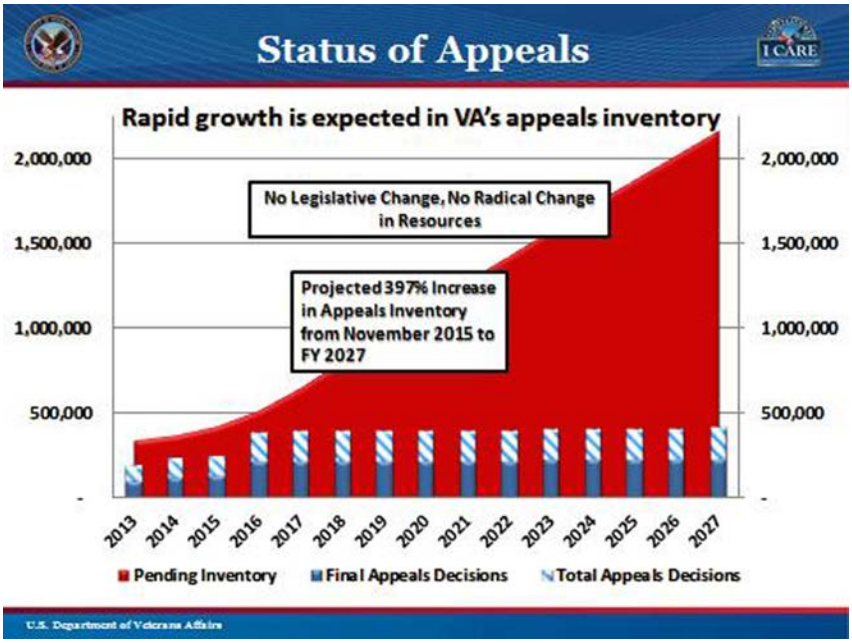
While the Simplified Appeals proposal would require FTE increases for the first several years to resolve the more than 440,000 currently pending appeals, by 2022, VA would be able to reduce appeals FTE to a sustainment level of roughly 1,030 FTE (including 980 FTE at the Board and 50 at VBA), a level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



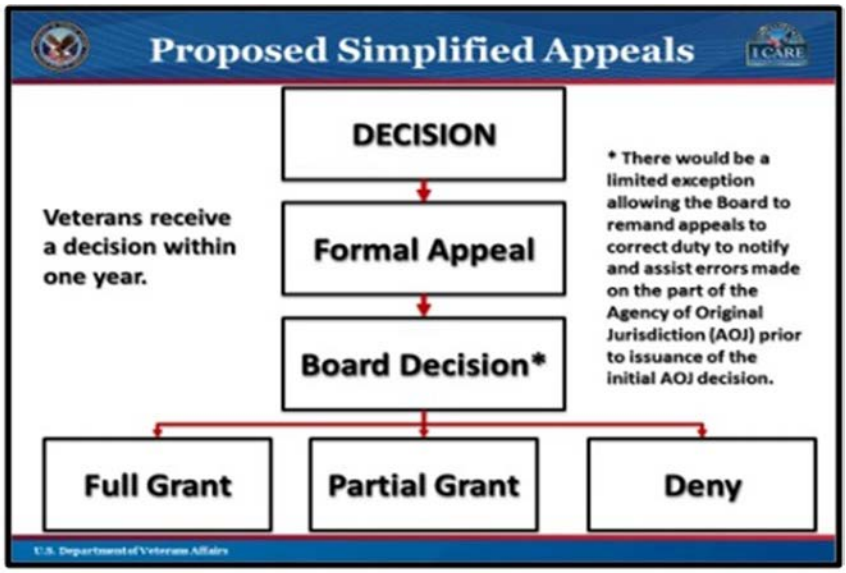
In today's Convoluted Appeals Process, Veterans Wait 5 Years for a Decision

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.



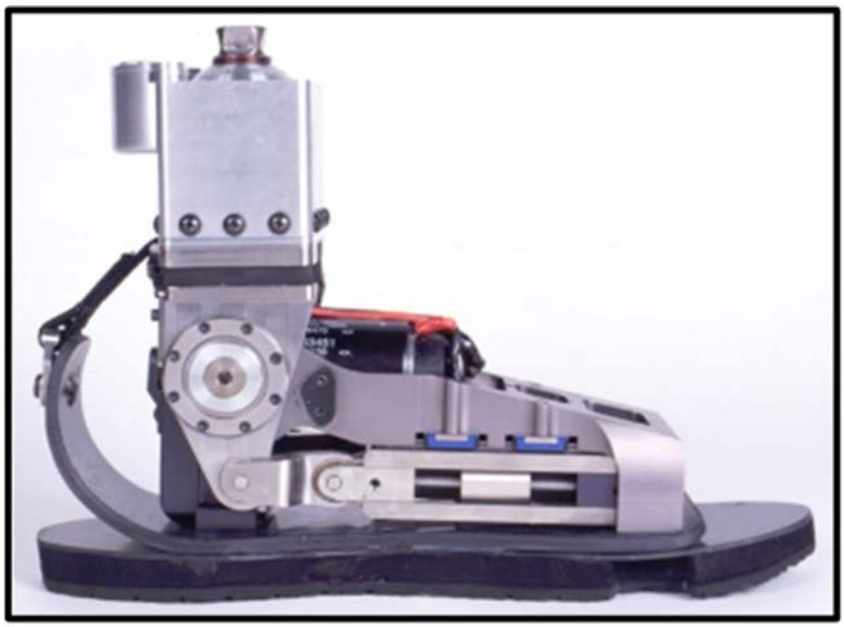
VA's Proposed Simplified Appeals Process: Veterans Receive an Appeal Decision Within One Year

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."

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 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.

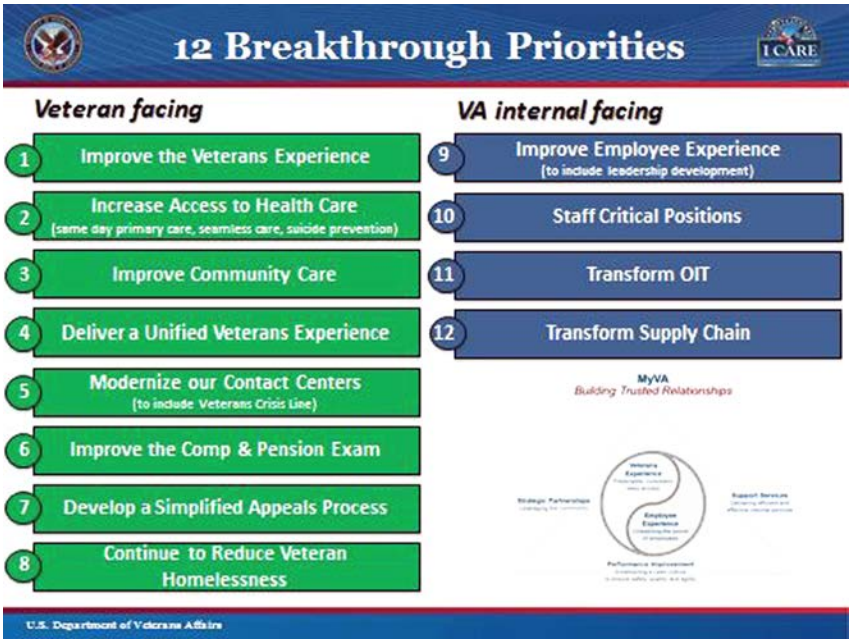
The fiscal year 2017 budget will make investments toward the five critical MyVA objectives:

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 b'udget 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 shortstaffed 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 nonveterans, 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?

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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.]

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

THURSDAY, APRIL 7, 2016

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

The subcommittee met at 10:34 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Mark Kirk (chairman) presiding.

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

DEPARTMENT OF DEFENSE

OFFICE OF THE SECRETARY OF DEFENSE

STATEMENT OF PETER J. POTOCHNEY, PERFORMING THE DUTIES OF ASSISTANT SECRETARY OF DEFENSE, ENERGY, INSTALLATIONS AND ENVIRONMENT

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. The subcommittee will come to order. This is the third hearing for fiscal year 2017.

I want to welcome my friend Senator Jon Tester, who we hope will be with us at some point later on. He is on the way, I think.

I want to welcome our four witnesses from the Office of Secretary Mr. Pete Potochney; from the Army, Assistant Secretary Katherine Hammack; from the Navy, Principal Deputy Assistant Secretary Iselin; and from the Air Force, we have Assistant Secretary Miranda Ballentine.

We will proceed in this hearing with the early bird rule, alternating sides. I ask members to defer from any opening statements, and we will go to 5-minute question rounds.

I will just hold off here, waiting for Mr. Tester to come, then we will formally begin. We will just suspend for Jon Tester, the senior Senator for the Big Sandy metroplex.

Let's go to our statements. In this hearing, I want to hear how the funding that is being requested directly supports the Nation's men and women in uniform and how our military strategy is supported by the request.

Military construction is more than just bricks and mortar. It is also something that is a vital part of the strategic goals of the United States.

I want to hear more about how the request strengthens our ballistic missile defenses with key allies like Poland. I want to hear how this request supports the missile defense in Redzikowo, Poland, and to hear how this request improves the quality of life for our men and women who choose to wear the uniform, and specifically the quality and safety of the places where they live.

I want to recognize our witnesses for their opening remarks. We will start you guys off.

Pete, why don't you kick it off?

SUMMARY STATEMENT OF PETER J. POTOCHNEY

Mr. POTOCHNEY. Thank you, sir. I am Pete Potochney, currently the Deputy Assistant Secretary for basing and also the Acting right now, performing the duties of Assistant Secretary for Energy, Installations, and Environment, and have been acting in that capacity since December and will continue to do so until we have a nominee and confirmation.

I am pleased, proud, and honored to be here. I appreciate this opportunity to talk to you, and I also will appreciate my remarks being in the record.

Senator KIRK. Without objection.

Mr. POTOCHNEY. I'll be very brief. The people at this table, in my view, and I know for myself, are doing the best we can in a tough budget environment. Mr. Chairman, you talked about things like quality of life, and how our construction is supporting our readiness and our capabilities and the men and women who serve us so well. That is what we are about.

We do the best we can to ensure that those dollars are spent wisely, and we do the best we can to compete for those resources within a tough budget environment. That is what we do. We fight pretty strongly for those resources.

In that regard, in a tough budget environment, we are asking once again for base realignment and closure (BRAC). We need it. It allows us to avoid wasting resources on unnecessary facilities and channeling those resources into our readiness and quality of life, and they are directly linked.

So we ask that you entertain that, because we do feel it is important.

And I will conclude my remarks with that. Thank you.

[The statement follows:]

PREPARED STATEMENT OF PETER J. POTOCHNEY

INTRODUCTION

Chairman Kirk, Ranking Member Tester and distinguished members of the subcommittee: Thank you for the opportunity to present the President's fiscal year 2017 budget request for the Department of Defense programs supporting energy, installations, and the environment.

In my testimony, I will focus first on the budget request. As you will note, the administration's budget includes $7.4 billion for Military Construction (including family housing), and $10.2 billion for Facility Sustainment and Recapitalization. These are both decreases from last year, as the Bipartisan Budget Act of 2015 caps overall defense spending. Although this request allows a reduction in facilities risk due to a slight increase in Sustainment funding by the services, the Department is still accepting risk in facilities. As this subcommittee well knows, facilities degrade more slowly than readiness, and in a constrained budget environment, it is responsible to take risk in facilities first.

My testimony will also address the environmental budget. This budget has been relatively stable, and we continue to show progress in both our compliance program, where we've seen a decrease in environmental violations, and in cleanup, where 84 percent of our 39,000 sites have reached Response Complete. We remain on track to meet our goals of 90 percent Response Complete in 2018, and 95 percent in 2021.

As you know, Operational Energy Plans and Programs merged with Installations and Environment office in 2015 to form the Office of Assistant Secretary of Defense for Energy, Installations and Environment (EI&E). EI&E now oversees all energy that is required for training, moving and sustaining military forces and weapons platforms for military operations, as well as energy used on military installations. While the budget request for Military Construction and Environmental Remediation programs includes specific line items, the Department's programs for Operational Energy and Installation Energy are subsumed into other accounts. With that in mind, I will summarize the newly released 2016 Operational Energy Strategy and address the budgets for the Department's operational and installation energy portfolio.

In addition to budget, I will also highlight a handful of top priority issues—namely, the administration's request for BRAC authority, European consolidation efforts, European Reassurance Initiative, the status of the movement of Marines from Okinawa to Guam, an overview of our energy programs, and climate change.

FISCAL YEAR 2017 BUDGET REQUEST—MILITARY CONSTRUCTION AND FAMILY HOUSING

The President's fiscal year 2017 budget requests $7.4 billion for the Military Construction (MILCON) Appropriation—a decrease of approximately $1.0 billion from the fiscal year 2016 budget request (see Table 1 below). This decrease is directly attributable to the resourcing constraints established by the Bipartisan Budget Agreement and the Department's need to fund higher priority readiness and weapon's modernization program. The request does recognize the Department's need to invest in facilities that address critical mission requirements and life, health, and safety concerns, while acknowledging the constrained fiscal environment. In addition to new construction needed to bed-down forces returning from overseas bases, this funding will be used to restore and modernize enduring facilities, acquire new facilities where needed, and eliminate those that are excess or obsolete. The fiscal year 2017 MILCON request includes projects that directly support operations and training, maintenance and production, and projects to take care of our people and their families, such as medical treatment facilities, unaccompanied personnel housing, and schools.

As shown by the decrease in this year's budget request, the DOD Components continue to take risk in the MILCON program in order to lessen risk in other operational and training budgets. While the Department's fiscal year 2017 budget request funds critical projects that sustain our warfighting and readiness postures, taking continued risk across our facilities inventory will degrade our facilities and result in the need for significant investment for facility repair and replacement in the future. Our limited MILCON budget for fiscal year 2017 leaves limited room for projects that would improve aging workplaces, and therefore, could adversely impact routine operations and the quality of life for our personnel.

TABLE 1. MILCON APPROPRIATION REQUEST, FISCAL YEAR 2016 VERSUS FISCAL YEAR 2017

Account Category	Fiscal Year 2016 Request ($ Millions)	Fiscal Year 2017 Request ($ Millions)	Change From Fiscal Year 2016	
			Funding ($ Millions)	Percent
Military Construction	6,653	5,741	(912)	(14)
Base Realignment and Closure	251	205	(46)	(18)
Family Housing	1,413	1,320	(93)	(7)
Chemical Demilitarization	0	0	0	0
NATO Security Investment Program	120	178	58	48
TOTAL	8,437	7,444	(993)	(12)

MILITARY CONSTRUCTION

The fiscal year 2017 military construction request of $6.1 billion addresses routine requirements for construction at enduring installations stateside and overseas, and for specific programs such as Base Realignment and Closure and the NATO Security

Investment Program. This is a 13 percent decrease from our fiscal year 2016 request, and this level of funding remains significantly less than historic trends prior to the Budget Control Act. In addition, we are targeting MILCON funds to three key areas.

First and foremost, our MILCON request supports the Department's operational missions. MILCON is key to supporting forward deployed missions as well as implementing initiatives such as the Asia-Pacific rebalance, European Infrastructure Consolidation, European Reassurance Initiative, and cyber mission effectiveness. Our fiscal year 2017 budget request includes $473 million for 13 F–35A/B/C maintenance, production, training, and support projects to accommodate initial F–35 deliveries; $194 million to support 8 fuel infrastructure projects; $62.2 million for a power upgrades utility project in support of the U.S. Marines relocation to Guam; $260 million for recapitalization of National Security Agency facilities; and $53.1 million for the third phase of a Joint Intelligence Analysis Complex Consolidation at Royal Air Force Croughton, United Kingdom. The budget request also includes $470 million to address new capabilities/mission, force structure growth, and antiquated infrastructure for Special Operations Forces; $176 million for 3 Missile Defense Agency projects, including $156 million for Phase 1 of the Long Range Discrimination Radar System Complex in Alaska; a $76 million investment to recapitalize facilities at three Naval Shipyards; and $124 million for 4 unmanned aerial vehicle operational facilities.

Second, our fiscal year 2017 military construction budget request continues the Department's 10 year plan (which started in fiscal year 2011) to replace and recapitalize more than half of the DODEA schools. Funding in fiscal year 2017 includes $246 million to address four schools in poor condition at Dover, Delaware; Kaiserslautern, Germany; Kadena AB, Japan; and RAF Croughton, United Kingdom.

Third, the fiscal year 2017 budget request includes $304 million for medical facility recapitalization. This includes $50 million for the first increment of a $510 million project for the Walter Reed Medical Center Addition/Alteration; $58.1 million for increment six (of a $982 million seven increment project) for the Medical Center Replacement at Rhine Ordnance Barracks in Germany; and $195.9 million for five other smaller medical/dental facilities. All the projects are crucial for our continued delivery of quality healthcare that our service members and their families deserve whether stationed stateside or during overseas deployments.

OVERSEAS CONTINGENCY OPERATIONS

The fiscal year 2017 Overseas Contingency Operations budget request includes $47.9 million for projects supporting the mission in East Africa (Djibouti). The request also includes $113.6 million in European Reassurance Initiative military construction funding for military construction activities for the Active components of all Military Services, and Defense-Wide Activities supporting military operations in Europe in direct support of NATO, Operation Freedom's Sentinel, and Operation Inherent Resolve. Funds provided would bolster security of U.S. NATO Allies and partner states in Europe and deter aggressive actors in the region by enhancing prepositioning and weapons storage capabilities, improving airfield and support infrastructure, providing 5th generation warfighting capability, and building partnership capacity.

FAMILY AND UNACCOMPANIED HOUSING

A fundamental priority of the Department is to support military personnel and their families to improve their quality of life by ensuring access to suitable, affordable housing. Service members are engaged in the front lines of protecting our national security and they deserve the best possible living and working conditions. Sustaining the quality of life of our people is crucial to recruitment, retention, readiness and morale.

Our fiscal year 2017 budget request includes $1.3 billion to fund construction, operation, and maintenance of Government-owned and leased family housing worldwide as well as to provide housing referral services to assist military members in renting or buying private sector housing, and oversight of privatized family housing (see Table 2 below). Included in this request is $356 million for construction and improvements; $232 million for operations (including housing referral services); $229 million for maintenance; $154 million for utilities; and $349 million for leasing and privatized housing oversight.

This funding request supports over 38,000 Government-owned family housing units, almost all of which are on enduring bases in foreign countries now that the Department has privatized the vast majority of our family housing in the United

States (over 206,000 units). The Department is also leasing more than 9,000 family housing units where Government-owned or privatized housing is not feasible. Our request also includes $3.3 million to support administration of the Military Housing Privatization Initiative (MHPI) Program as prescribed by the Federal Credit Reform Act of 1990, to ensure the project owners continue to fund future capital repairs and replacements as necessary to provide quality housing for military families and to ensure that these projects remain viable for their 40–50 year lifespan.

In fiscal year 2015, the Department notified Congress of DOD's intent to transfer $96 million of Navy family housing construction funds into the Department's Family Housing Improvement Fund (FHIF) to execute Hawaii Phase 6 to support Marine Corps housing requirements in Hawaii. Execution of Hawaii Phase 6 brings the Department's total privatized family housing inventory to nearly 202,000 homes.

TABLE 2. FAMILY HOUSING BUDGET REQUEST, FISCAL YEAR 2016 VERSUS FISCAL YEAR 2017

Account Category	Fiscal Year 2016 Request ($ Millions)	Fiscal Year 2017 Request ($ Millions)	Change From Fiscal Year 2016	
			Funding ($ Millions)	Percent
Family Housing Construction/Improvements	277	356	79	29
Family Housing Operations & Maintenance	1,136	961	(175)	(15)
Family Housing Improvement Fund [1]	0	3	3	100
TOTAL	1,413	1,320	93	(7)

[1] We made no fiscal year 2016 request for funds to oversee privatized housing because we had sufficient fiscal year 2015 cost savings to cover our fiscal year 2016 expenses.

The Department also continues to encourage the modernization of Unaccompanied Personnel Housing (UPH) to improve privacy and provide greater amenities. In recent years, we have heavily invested in UPH to support initiatives such as BRAC, global restationing, force structure modernization, and the Navy's Homeport Ashore initiative. However, this constrained budget request only includes five UPH projects totaling $161 million, all of which are for transient personnel or trainees such as a $67 million Recruit Dormitory at Joint Base San Antonio, Texas.

FACILITIES SUSTAINMENT AND RECAPITALIZATION

In addition to new construction, the Department invests significant funds in maintenance and repair of our existing facilities. Sustainment represents the Department's single most important investment in the condition of its facilities. It includes regularly scheduled maintenance and repair or replacement of facility components—the periodic, predictable investments that should be made across the service life of a facility to slow its deterioration, optimize the Department's investment, and save resources over the long term. Proper sustainment slows deterioration, maintains safety, preserves performance over the life of a facility, and helps improve the productivity and quality of life of our personnel.

TABLE 3. SUSTAINMENT AND RECAPITALIZATION BUDGET REQUEST, FISCAL YEAR 2016 VERSUS FISCAL YEAR 2017

Account Category	Fiscal Year 2016 Request ($ Millions)	Fiscal Year 2017 Request ($ Millions)	Change From Fiscal Year 2016	
			Funding ($ Millions)	Percent
Sustainment (O&M)	8,022	7,450	(572)	(7)
Recapitalization (O&M)	2,563	2,088	(475)	(19)
TOTAL	10,585	9,538	(1,047)	(10)

The accounts that fund these activities have taken significant cuts in recent years. For fiscal year 2017, the Department's budget request includes $7.4 billion for sustainment and $2.1 billion for recapitalization (see Table 3 above) in Operations & Maintenance funding only. The combined level of sustainment and recapitalization funding ($9.5 billion) is a 10 percent decrease from the fiscal year 2016 President's budget (PB) request ($10.6 billion), and reflects an acceptance of significant risk in DOD facilities. In fact, the request supports average DOD-wide sustainment funding level that equates to 74 percent of the FSM requirement as compared to the Department's goal to fund sustainment at 90 percent of modeled requirements.

Recent and ongoing budget constraints have limited investment in facilities sustainment and recapitalization to the point that 11.7 percent of the Department's facility inventory is in "poor" condition (Facility Condition Index (FCI) between 60 and 79 percent) and another 14.8 percent is in "failing" condition (FCI below 60 percent) based on recent facility condition assessment data. Compared to last year (see Table 4), the Department is seeing more poor facilities moving into failing conditions. Until the out-year sequestration challenges are overcome, the Department will continue to take risk in funding to sustain and recapitalize existing facilities. This will ultimately result in DOD facing larger bills in the out-years to restore or replace facilities that deteriorate prematurely.

TABLE 4.—COMPARISON OF FISCAL YEAR 2014 AND FISCAL YEAR 2015 FACILITY CONDITION INDICES

	End of Fiscal Year 2014 FCI (%)		End of Fiscal Year 2015 FCI (%)	
	Poor (60–79%)	Failing (<60%)	Poor (60–79%)	Failing (<60%)
Army	31.3	10.2	12.8	26.1
Navy	17.4	6.4	15.8	6.4
Air Force	2.6	4.1	5.7	3.9
Washington Headquarters Service	2.2	4.7	2.1	5.8
TOTAL	19.7	7.4	11.7	14.8

FISCAL YEAR 2017 BUDGET REQUEST—ENVIRONMENTAL PROGRAMS

The Department has long made it a priority to protect the environment on our installations, not only to preserve irreplaceable resources for future generations, but to ensure that we have the land, water and airspace we need to sustain military readiness. To achieve this objective, the Department has made a commitment to continuous improvement, pursuit of greater efficiency and adoption of new technology. In the President's fiscal year 2017 budget, we are requesting $3.4 billion, a slight decrease from fiscal year 2016, to continue the legacy of excellence in our environmental programs.

The table below outlines the entirety of the DOD's environmental program, but I would like to highlight a few key elements where we are demonstrating significant progress—specifically, our environmental restoration program, our efforts to leverage technology to reduce the cost of cleanup, and the Readiness and Environmental Protection Integration (REPI) program.

TABLE 5: ENVIRONMENTAL PROGRAM BUDGET REQUEST, FISCAL YEAR 2017 VERSUS FISCAL YEAR 2016

Account Category	Fiscal Year 2016 Request ($ Millions)	Fiscal Year 2017 Request ($ Millions)	Change From Fiscal Year 2016	
			Funding ($ Millions)	Percent
Environmental Restoration	1,107	1,030	−77	−7
Environmental Compliance	1,389	1,493	103	7
Environmental Conservation	389	420	31	8
Pollution Prevention	101	84	−17	−17
Environmental Technology	200	186	−14	−7
BRAC Environmental	217	181	−36	−17
TOTAL	3,405	3,395	−10	−0.3

ENVIRONMENTAL RESTORATION

We are requesting $1.2 billion to continue cleanup efforts at remaining Installation Restoration Program (IRP—focused on cleanup of hazardous substances, pollutants, and contaminants) and Military Munitions Response Program (MMRP—focused on the removal of unexploded ordnance and discarded munitions) sites. This includes $1.0 billion for "Environmental Restoration," which encompasses active installations and Formerly Used Defense Sites (FUDS) locations and $181 million for "BRAC Environmental." The amount of BRAC Environmental funds requested will be augmented by $108 million of land sale revenue and prior year, unobligated

funds, bringing the total amount of BRAC Environmental funding planned for obligation in fiscal year 2017 to $289 million. These investments help to ensure DOD continues to make property at BRAC locations safe and environmentally suitable for transfer. We remain engaged with the Military Departments to ensure they are executing plans to spend remaining unobligated balances in the BRAC account.

TABLE 6: PROGRESS TOWARD CLEANUP GOALS

Goal: Achieve Response Complete at 90% and 95% of Active and BRAC IRP and MMRP sites, and FUDS IRP sites, by fiscal year 2018 and fiscal year 2021, respectively

	Status as of the end of fiscal year 2015 (%)	Projected Status at the end of fiscal year 2018 (%)	Projected Status at the end of fiscal year 2021 (%)
Army	90	94	97
Navy	80	86	92
Air Force	80	89	94
DLA	86	97	97
FUDS	80	89	94
Total	84	91	95

We are cleaning up sites on our active installations in parallel with those on bases closed in previous BRAC rounds—cleanup is not something that DOD pursues only when a base is closed. In fact, the significant progress we have made over the last 20 years cleaning up contaminated sites on active DOD installations is expected to reduce the residual environmental liability in the disposition of our property made excess through the BRAC process or other efforts.

By the end of 2015, the Department, in cooperation with State agencies and the Environmental Protection Agency, completed cleanup activities at 84 percent of Active and BRAC IRP and MMRP sites, and FUDS IRP sites, and is now monitoring the results. During fiscal year 2015 alone, the Department completed cleanup at over 870 sites. Of the roughly 39,500 restoration sites, almost 31,500 are now in monitoring status or cleanup completed. We are currently on track to meet our program goals—anticipating complete cleanup at 95 percent of Active and BRAC IRP and MMRP sites, and FUDS IRP sites, by the end of 2021.

Our focus remains on continuous improvement in the restoration program: minimizing overhead; adopting new technologies to reduce cost and accelerate cleanup; refining and standardizing our cost estimating; and improving our relationships with State regulators through increased dialogue. All of these initiatives help ensure that we make the best use of our available resources to complete cleanup.

ENVIRONMENTAL TECHNOLOGY

A key part of DOD's approach to meeting its environmental obligations and improving its performance is its pursuit of advances in science and technology. The Department has a long record of success when it comes to developing innovative environmental technologies and getting them transferred out of the laboratory and into actual use on our remediation sites, installations, ranges, depots and other industrial facilities. These same technologies are also now widely used at non-Defense sites helping the Nation as a whole.

While the fiscal year 2017 budget request for Environmental Technology overall is $191 million, our core efforts are conducted and coordinated through two key programs—the Strategic Environmental Research and Development Program (SERDP—focused on basic research) and the Environmental Security Technology Certification Program (ESTCP—which validates more mature technologies to transition them to widespread use). The fiscal year 2017 budget request includes $65 million for SERDP and $32 million for ESTCP for environmental technology demonstrations, with an additional $20 million requested specifically for energy technology demonstrations.

These programs have already achieved demonstrable results and have the potential to reduce the environmental liability and costs of the Department—developing new ways of treating groundwater contamination, reducing the life-cycle costs of multiple weapons systems, and improving natural resource management.

As an example, this past year SERDP-sponsored project to conduct basic research that is will develop an environmentally benign Chemical Agent Resistant Coating (CARC), which is critical technology for the protection of military assets. Current CARC coatings contribute approximately 2.3 million pounds of volatile organize compounds (VOCs) and hazardous air pollutants (HAPs) to the environment each

year. The new novel powder CARC is absent of solvent, emits nearly zero VOCs, can be recycled, and is compatible with existing CARC systems. In addition, testing to date proves that the exterior durability of this coating is superior to any liquid CARC system, supporting DOD's initiative for corrosion prevention and mitigation. Coating products are currently in transition to Original Equipment Manufacturers, Depots, and the Defense Logistics Agency (DLA).

Looking ahead, our environmental technology investments are focused on the Department's evolving requirements. In the area of Environmental Restoration, we are launching a new 3-year initiative to support sustainable range management by researching the environmental impacts of new munitions compounds and we will continue our investments in technologies to address the challenges of contaminated groundwater sites where no good technical solutions are currently available. We are working to understand the behavior of contaminants in fractured bedrock and large dilute plumes, which represent a large fraction of these sites, and to develop treatment and management strategies. We will continue our efforts to develop the science and tools needed to meet the Department's obligations to assess and adapt to climate change. Finally, to transition the important work of improving the sustainability of our industrial operations and reducing life-cycle costs by eliminating toxic and hazardous materials from our production and maintenance processes we are initiating a program to demonstrate that our most hazardous chemicals can be eliminated from a maintenance production line.

ENVIRONMENTAL CONSERVATION AND COMPATIBLE DEVELOPMENT

To maintain access to the land, water and airspace needed to support our mission needs, the Department continues to successfully manage the natural resources entrusted to us—including protecting the many threatened and endangered species found on our lands. DOD manages approximately 25 million acres containing many high-quality and unique habitats that provide food and shelter for nearly 520 species-at-risk and over 400 that are federally listed as threatened or endangered species. That is 9 times more species per acre than the Bureau of Land Management, 6 times more per acre than the United States Fish and Wildlife Service (USFWS), 4.5 times more per acre than the Forest Service, and 3.5 times more per acre than the National Park Service. A surprising number of rare species are found only on military lands—including more than 15 listed species and at least 75 species-at-risk.

The fiscal year 2017 budget request for Conservation is $420 million. The Department invests these funds to manage its imperiled species as well as all of its natural resources in an effort to sustain the high quality lands our service personnel need for testing, training and operational activities, and to maximize the flexibility our servicemen and women need to effectively use those lands. Species endangerment and habitat degradation can and does have direct mission-restriction impacts. That is one reason we work hard to prevent species from becoming listed and, if they do become listed, to manage these species and their habitat in ways that sustain the resource and enable our ability to test and train. All of our plans now adequately address these species, and we have successfully and consistently avoided critical habitat designations because our plans adequately address management concerns for species that exist on our lands. Getting ahead of any future listings has been a prime, natural resource objective for the last several years and will remain so in the future.

Readiness and Environmental Protection Integration (REPI) Program

To help ensure DOD sustains its national defense mission and protects species under duress, the Department has developed a strategy that supports conservation beyond installation boundaries. Under this strategy DOD engages with other governmental and non-governmental partners, as well as private landowners, to develop initiatives and agreements for protecting species for the purposes of precluding or mitigating regulatory restrictions on training, testing, and operations on DOD lands. Expanding the scale and options for protecting species on non-DOD land benefits conservation objectives while helping sustain access to, and operational use, of DOD live training and test domains.

This strategic focus is a key element of the Readiness and Environmental Protection Integration (REPI) Program. Under REPI, the Department partners with conservation organizations and State and local governments to preserve buffer land and sensitive habitat near installations and ranges. Preserving these areas allows the Department to avoid more costly alternatives such as workarounds, restricted or unrealistic training approaches, or investments to replace existing test and training capability. Simultaneously, these efforts ease the on-installation species management burden and reduce the possibility of restricted activities, ultimately providing more flexibility for commanders to execute their missions.

Included within the $420 million for Conservation, $60 million is directed to the REPI Program. The REPI Program is a cost-effective tool to protect the Nation's existing training, testing, and operational capabilities at a time of decreasing resources. In the last 13 years, REPI partnerships have protected more than 437,000 acres of land around 86 installations in 29 States. In addition to the tangible benefits to training, testing, and operations, these efforts have resulted in significant contributions to biodiversity and recovery actions supporting threatened, endangered and candidate species.

The REPI Program supports the warfighter and protects the taxpayer because it multiplies the Department's investments through unique cost-sharing agreements. Even in these difficult economic times, REPI is able to directly leverage the Department's investments at least one-to-one with those of our partners, effectively securing critical buffers around our installations for half-price.

In addition, DOD, along with the Departments of the Interior and Agriculture, continues to advance the Sentinel Landscapes Partnership to protect large landscapes where conservation, working lands, and national defense interests converge—places defined as Sentinel Landscapes. Established in 2013, the Sentinel Landscapes Partnership further strengthens interagency coordination and provides taxpayers with the greatest leverage of their funds by aligning Federal programs to advance the mutually-beneficial goals of each agency.

Thus far, three Sentinel Landscapes have been identified around Joint Base Lewis-McChord, Washington; Fort Huachuca, Arizona; and Naval Air Station (NAS) Patuxent River and the Atlantic Test Ranges, Maryland. The pilot Sentinel Landscape project at JBLM influenced the USFWS decision to avoid listing a butterfly species in Washington, Oregon, and California. The USFWS cited the "high level of protection against further losses of habitat or populations" from investments made by Joint Base Lewis-McChord's REPI partnership, actions that allow significant maneuver areas to remain available and unconstrained for active and intense military use at JBLM. At Fort Huachuca, NAS Patuxent River and the Atlantic Test Ranges, DOD is working with USFWS, the Natural Resources Conservation Service, the U.S. Forest Service, and a variety of State and private conservation organizations to protect important swaths of special use airspace used for aircraft testing and training, while also benefiting ecologically sensitive watersheds and the installations, wildlife, and working lands dependent on those resources.

FISCAL YEAR 2017 BUDGET REQUEST—ENERGY PROGRAMS

Unlike the Department's Military Construction and Environmental Remediation programs, where the budget request includes specific line items, our energy programs are subsumed into other accounts. The following sections describe the Energy portion of the budget request. Further discussion of energy follows in the highlighted issues section.

OPERATIONAL ENERGY

In fiscal year 2017, the Department's budget request includes an estimated $9.8 billion for 93.3 million barrels of fuel. In order to increase warfighting capability and reduce operational risk, the Department's fiscal year 2017 budget request also includes $2.5 billion for adaptations and improvements in our use of operational energy. Operational energy is the energy used to power aircraft, ships, combat vehicles, and mobile power generation at contingency bases. While there is no explicit budget request for Operational Energy, these investments across multiple accounts and appropriations are intended specifically to improve military capability.

Within this overall request, the Department is requesting $37.3M in RDT&E funding to support the Operational Energy Capabilities Improvement Fund (OECIF). OECIF provides funding to DOD research programs that improve operational energy performance organized around a specific annual theme or focus area, as well as sustain funding to those programs already underway. The fiscal year 2017 President's budget will provide funding for new programs, as well as support those programs established in fiscal year 2014–fiscal year 2016.

Finally, the Department is requesting $5.4 million in fiscal year 2017 to fund the operations of OASD(EI&E) and oversee operational energy activities. Each year, EI&E certifies that the President's budget is adequate for carrying out the Department's Operational Energy Strategy. The full certification report, which will be provided to Congress in the near future, will provide a more comprehensive assessment of the alignment of operational energy initiatives with the goals of the recently released 2016 Operational Energy Strategy.

2016 Operational Energy Strategy

Reflecting lessons learned, strategic guidance, and the evolving operational environment, the 2016 Operational Energy Strategy is designed to improve our ability to deliver the operational energy needed to deploy and sustain forces in an operational environment characterized by peer competitors, asymmetric insurgents, and unforgiving geography. The strategy identifies the following three objectives:

—*Increase Future Warfighting Capability.* Foremost, the strategy focuses on increasing warfighter capability through energy-informed force development. In addition to energy Key Performance Perimeters (eKPP) informed by energy supportability analyses that improve the combat effectiveness and supportability of major acquisition programs, the Department will continue to invest in energy innovation that improves the long-term capability of the Department, such as increasing the unrefueled range or endurance of platforms. With this knowledge of inherent energy constraints and risks, the Military Departments will be better able to make energy-informed decisions related to force development and future capabilities.

—*Identify and Reduce Logistics and Operational Risks.* To effectively reduce logistics risks, the Department will address energy risks in near-term operation plans as well as more exploratory, longer-term concepts of operation. Initiatives that fall into this category seek to mitigate warfighting gaps found in Integrated Priority Lists, OPLANs, and wargames. The Department's focus on risk will ensure future forces are better aligned to mitigate potential threats to operations.

—*Enhance Mission Effectiveness of the Current Force.* Finally, the strategy will improve the effectiveness of U.S. Forces operating around the globe today. To do so, the Department will emphasize improved energy use in operations and training, and enhanced education of operators, logisticians, and system developers. These initiatives may include material and non-material enhancements to day to day operations, as well as adaptations in training, exercises, and professional military education.

In coordination with the Combatant Commands, Military Departments, Joint Staff, and Defense Agencies, my office is overseeing the execution of 15 targets arrayed across the three objectives. For instance, we are supporting Joint Staff oversight of the energy KPP, facilitating operational energy advisors at the Combatant Commands, and assessing the role of operational energy in war games and operation plan reviews. In addition to the Defense Operational Energy Board, we will use existing requirements, acquisition, programming, and budgeting processes to review Department progress against these targets.

INSTALLATION ENERGY

As with Operational Energy, there is no explicit request in the overall budget for Facilities Energy—utilities expenditures are included in the Base Operations O&M request. Facilities Energy remains our single largest base operating cost and in fiscal year 2015, we spent $3.9 billion to heat, cool, and provide electricity to our buildings. To reduce this cost the Department is pursuing energy efficiencies through building improvements, new construction, and third party investments.

The Department's fiscal year 2017 budget request includes approximately $618 million for investments in conservation and energy efficiency, most of which will be directed to existing buildings. The majority ($468 million) is in the Military Components' operations and maintenance accounts, to be used for sustainment and recapitalization projects. Such projects typically involve retrofits to incorporate improved lighting, high-efficiency HVAC systems, double-pane windows, energy management control systems, and new roofs. The remainder ($150 million) is for the Energy Conservation Investment Program (ECIP), a Military Construction account used to implement energy efficiency, water conservation, and renewable energy projects. Each individual ECIP project has a positive payback (i.e. Savings to Investment Ratio (SIR) > 1.0) and the overall program has a combined SIR greater than 2.0. This means for every dollar we invest in ECIP, we generate more than two dollars in savings.

The Military Component investments include activities that would be considered regular maintenance and budgeted within the O&M accounts for Facilities Sustainment, Restoration, and Maintenance activities. The risk that has been accepted in those accounts will not only result in fewer energy projects, but failing to perform proper maintenance on our buildings will without question have a negative impact on our energy usage. In plain terms, upgrades to air conditioning sys-

tems will not reduce energy usage as projected if the roof is leaking or the windows are broken.

In addition to retrofitting existing buildings, we continue to drive efficiency in our new construction. Our new buildings must be constructed using the high-performance sustainable buildings standards issued by my office 2 years ago which include greater energy efficiency requirements.

Additionally, the Department is taking advantage of third-party financing through Energy Savings Performance Contracts (ESPCs) and Utility Energy Service Contracts (UESCs), to implement energy efficiency improvements in our existing buildings. Under these contracts private energy firms or utility companies make energy upgrades to our buildings and are paid back over time using utility bill savings.

Facilities Energy Management

With respect to facilities energy management the Department has made great progress towards improving the energy efficiency of its installations. Since fiscal year 2009, the Department reduced the energy consumed on our military bases by 10 percent, avoiding over $1.2 billion in operating costs.

In addition to using appropriated funding for energy conservation and efficiency initiatives, the Department is continuing to take advantage of third-party financing tools through energy performance based contracts (ESPCs and UESCs) to implement energy efficiency improvements in our existing buildings. While such performance-based contracts have long been part of the Department's energy strategy, the Services have significantly increased the use of ESPCs and UESCs in response to the President's Performance Contracting Challenge (PPCC) originally issued in December 2011 and extended in May 2014. The PPCC challenged Federal agencies to award $4 billion in energy performance based contacts by the end December 2016. The DOD's commitment to the challenge is just over $2 billion in contracts. To date the Department has awarded $1.3 billion in ESPCs and UESCs.

Regarding renewable energy, the Department has a goal to deploy 3 gigawatts of renewable energy by fiscal year 2025. Most renewable energy projects we pursue are financed by private developers. DOD's authorities for renewable energy—particularly the ability to sign power purchase agreements of up to 30 years—provide incentives for private firms to fund the projects themselves, and can also provide a strong business case that they are able to offer DOD lower energy rates than are being paid currently. The DOD does not make any capital investment in these renewable energy projects. When feasible, renewable energy projects are being built with micro-grid-ready applications that can enable the provision of continuous power in the event of a disruption.

As of the end of fiscal year 2015 the Department has 702 megawatts in renewable energy projects in operation. The services also have more than 550 megawatts of projects under construction including a 15 MW Solar PV/50 MW wind "hybrid" project at Ft Hood, Texas and an off-site 210 MW solar PV facility that will supply power to 14 Department of Navy installations in California. Further, there is another 1.3 gigawatts of renewable energy projects in various stages of development; putting the Department well on track towards meeting its 3 gigawatt goal.

HIGHLIGHTED ISSUES

MERGER OF THE ENERGY, INSTALLATIONS, AND ENVIRONMENT ORGANIZATIONS

As you know, the fiscal year 2015 National Defense Authorization Act directed the merger of the Assistant Secretary of Defense for Operational Energy Plans and Programs and the Deputy Under Secretary of Defense for Installations and Environment to create the Assistant Secretary of Defense for Energy, Installations and Environment. The ASD (EI&E) is now the principle advisor to the Secretary of Defense for Acquisition, Technology, and Logistics on matters relating to energy, installations, and environment and the principal advisor to the Secretary of Defense and the Deputy Secretary of Defense regarding operational energy plans and programs.

The Department is currently developing the required report on the status of the merger, and will provide that to the Congress later this year. I can tell you that through the merger operational energy functions have benefited from additional resources and collaboration with complementary functions related to installation energy, facilities investment and management, and basing.

BASE REALIGNMENT AND CLOSURE

Given the need to find efficiencies and reexamine how our infrastructure is configured, the Administration is requesting the authority from Congress to conduct a 2019 BRAC round. As indicated in testimony last year, the Department has excess

capacity. The Army and Air Force have analyzed their infrastructure and have found that they have 18 percent and 30 percent excess capacity, respectively. We are currently conducting a DOD wide parametric analysis as directed by the fiscal year 2016 National Defense Authorization Act, which will likely indicate excess of around 20 percent. This level of excess is not surprising given the fact that in 2004 we found that the Department had 24 percent excess and BRAC 2005 reduced infrastructure by 3.4 percent (as measured by plant replacement value).

As we have said, a new BRAC round will be different than BRAC 2005. The new round will be efficiency focused. It will save about $2 billion a year after implementation; with costs and savings during the 6 year implementation being a wash at approximately $7 billion. Our projection is based on the efficiency rounds of the 1990s.

In addition to being a proven process that yields savings, BRAC has several advantages that we have outlined before in our testimony. I want to highlight a few of these:

—BRAC is comprehensive and thorough—all installations are analyzed using certified data aligned against the strategic imperatives detailed in the 20-year force structure plan;

—The BRAC process is auditable and logical which enables the Commission to conduct an independent review informed by its own analysis and testimony from affected communities and elected officials;

—The Commission has the last say on the Department's recommendations—being fully empowered to alter, reject, or add recommendation;

—The BRAC process has an "All or None" construct which prevents the President and Congress from picking and choosing among the Commission's recommendations; thereby insulating BRAC from politics;

—The BRAC process imposes a legal obligation on the Department to close and realign installations as recommended by the Commission by a date certain that facilitates economic reuse planning by impacted communities and grants the Department the authorities needed to satisfy that legal obligation.

In recognition of your concerns about cost and the amount of time the BRAC Commission has to review our recommendations, the Department's request for BRAC authorization includes four key changes from prior year submissions as well as a handful of administrative and timeline changes. Each of the changes are narrowly tailored to address congressional cost concerns while not altering the fundamental principles of the BRAC process: treating all bases equally; all or none review by both the President and Congress; review by an independent Commission; making military value the priority consideration; and a clear legal obligation to implement all of the recommendations in a time certain together with all the authorities needed to accomplish implementation.

To ensure the next BRAC round is focused on saving money and maximizing efficiency, our legislation adds a requirement for the Secretary of Defense to certify that the BRAC round will have the primary objective of eliminating excess infrastructure to maximize efficiency and reduce cost. Like the existing requirement to certify the need for a BRAC round, this certification occurs at the outset of the BRAC process and is a precondition to moving forward with development of recommendations. Additionally, subject to the requirement to give priority consideration to the military value selection criteria, the legislation now requires the Secretary to emphasize those recommendations that yield net savings within 5 years of completing the recommendation and limits the Secretary's ability to make recommendations that do not yield savings within 20 years. In order to make a recommendation that does not yield savings within 20 years, the Secretary must expressly determine that the military value of such recommendation supports or enhances a critical national security interest of the United States.

Finally, the legislation also now specifically delineates those costs that must be considered when determining the costs associated with a recommendation. As revised, the legislation specifies that the Department must consider costs associated with military construction, information technology, termination of public-private contracts, guarantees, the costs of any other activity of the Department of Defense or any other Federal agency that may be required to assume responsibility for activities at the military installations, and such other factors as the Secretary determines as contributing to the cost of a closure or realignment. Previous versions of the legislation had only specifically mentioned the costs of any other activity of the Department of Defense or any other Federal agency that may be required to assume responsibility for activities at the military installations

Our proposal extends the Commission review period to run from April 15 to October 1 which adds 2 months to Commission review and requires that Commissioners

be named by February 1 which enables the Commission to be up and running for ten weeks before our recommendations come to them. Our revision also requires the Chair of the Commission to certify that the Commission and its staff have the capacity to review the Department's recommendations.

Heretofore, we've addressed every concern raised by Congress. We conducted the European Infrastructure Consolidation to address concerns that we need to look at overseas installations first; we programmed the costs and pledged the next round will reduce excess instead of the 2005 round's more costly "transformation" focus in response to concerns that we could not afford BRAC; and we have demonstrated that excess capacity exists—Army and Air Force testified to 21 and 30 percent. We've updated our DOD-wide (parametric) analysis and will provide it to Congress soon; it indicates over 20 percent excess.

We hope the Department's efforts will result in a real dialog with members of Congress regarding the need for and value of the BRAC process, ultimately resulting in authority for a 2019 BRAC round.

EUROPEAN INFRASTRUCTURE CONSOLIDATION

In response to our recent requests for BRAC authority, Congress made it clear that it wanted DOD to look at reducing our overseas infrastructure first—particularly in Europe. We did so by conducting the European Infrastructure Consolidation (EIC) analysis—the first holistic and joint review of our legacy infrastructure in Europe.

To analyze our European infrastructure we used a process very similar to the proven U.S. BRAC process. We looked at capacity, requirements (including surge), military value, cost, and the diplomatic dynamics involved with each action. As we consolidate our footprint, the infrastructure remaining in place will continue to support our operational requirements and strategic commitments, but we will not need as many support personnel (military, civilian, and host nation employees) to do so.

The 26 approved EIC actions will allow us to create long-term savings by eliminating excess infrastructure without reducing our operational capabilities. In other words, operationally we will continue to do everything we currently do but at a lower cost. After a one-time investment of approximately $800 million in Military Construction to implement 2 major base closures, 8 minor site closures, and 16 realignment actions, the Department will realize approximately $500 million in annual recurring savings.

These actions will be executed over the next several years, but that does not mean that everything will remain static in Europe while these changes occur. There were consolidations made before EIC and there will undoubtedly be future basing actions—especially given the evolving security environment. However, our holistic review and the resultant actions allow us to redirect resources supporting unneeded infrastructure and apply them to higher priorities, thus strengthening our posture in Europe.

Although we continually seek efficiencies as we manage installations worldwide, the Department does not conduct this degree of comprehensive analyses of its infrastructure on a regular basis. That's one of the reasons we have requested BRAC authority from Congress to do a review of our U.S. installations. In this fiscal environment it would be irresponsible of us not to look for such savings.

REBALANCE TO THE ASIA-PACIFIC

REBASING OF MARINES FROM OKINAWA TO GUAM

The movement of thousands of Marines from Okinawa (and elsewhere) to Guam is one of the most significant re-basing action in recent years. We appreciate Congress' support allowing us to move forward on this essential component of our rebalance to the Asia-Pacific region, resulting in a more geographically dispersed, operationally resilient, and politically sustainable posture in the area. As a U.S. territory, Guam offers strategic advantages and operational capabilities that are unique in the region. Presence in Guam is a force multiplier that contributes to a force posture that reassures allies and partners and deters aggression.

Now that the very complex National Environmental Policy Act (NEPA) process (nearly 5 years of study) is complete, there is a clear path for construction to proceed in earnest. Utilities and site improvements (~$300 million funded by the GoJ) for the main cantonment area at Finegayan, and a live-fire training range ($125 million) at Andersen's Northwest Field will be the first projects under the new Record of Decision (ROD). Construction for the Marine Aviation Combat Element (ACE) at the North Ramp of Andersen proceeded earlier because it was covered under the original 2010 ROD; it remains on track.

We understand Congress' concerns regarding both the cost and feasibility of the relocation and we are firmly committed to the principles of operational effectiveness and fiscal responsibility. We remain confident in the estimate of $8.7 billion for the program, which includes $3.1 billion provided by the Government of Japan (GoJ) ($1.152 billion transferred to date). The Department is evaluating this program in advance of each year's budget submission to pursue efficiencies that have the potential to reduce overall cost. For example, the Department's decision to relocate housing to Andersen Air Force Base reduced the requirement for a water works project (at the main cantonment area) saving the Department approximately $50 million. Additionally, we continue to provide the necessary oversight, conducting quarterly Deputy Secretary led Guam Oversight Council meetings to address issues related to the program's implementation.

The Marines, in conjunction with the Naval Facilities Engineering Command (NAVFAC), have an established program management organization for construction execution and oversight. NAVFAC is standing up an Officer in Charge of Construction office and anticipates it will be in place by the first quarter of 2017. The Marines continue with planning to meet operational requirements on the ground. This is the largest infrastructure program (~$9 billion) that has been executed in many years, so it is prudent to have the necessary management structure in place to ensure success.

The Economic Adjustment Committee Implementation Plan (EIP) (submitted to Congress in October 2015) was the last Congressional requirement restricting project execution on Guam. The Plan outlines the five "outside the fence" projects (listed in the table below) associated with the impacts of the build-up on Guam's civilian infrastructure. Last year's fiscal year 2016 NDAA provides authorization for moving forward with the water/wastewater projects—but not for the cultural repository and the public health lab projects. Our fiscal year 2017 President's budget requests authority for these two projects and the balance of funding ($87 million).

TABLE 7: EAC PROJECTS SUPPORTING DON RECORD OF DECISION

Project Title	Project Total ($ Millions)	Previous Fiscal Year(s) Appropriated ($ Millions)	Fiscal Year 2017 Request ($ Millions)
Upgrade Wastewater Treatment Plan	139	71	68
Refurbishment sewer line Andersen AF	31	31	0
Repair/expansion Aquifer monitoring system	4	4	0
Public Health Laboratory	32	13	19
Cultural Repository	12	12	0
Total	218	131	87

The cumulative impact of this stationing was carefully evaluated within the environmental analysis process and we determined that water/wastewater, public health, and our obligation to care for artifacts uncovered in our construction need to be addressed. The associated projects total $218 million, which is a relatively small, but absolutely necessary, portion of this relocation.

Failure to provide authorization for these projects increases the risk of litigation and project delay and will affect DOD's credibility with the Guam's populace. Our inability to meet commitments to the Government of Guam will also adversely affect our credibility with the Government and people of the Commonwealth of Northern Mariana Islands (CNMI) since they have similar concerns, as discussed below.

COMMONWEALTH OF NORTHERN MARIANA ISLANDS (CNMI) INITIATIVES

The Department continues to pursue two key military initiatives in CNMI—the CNMI Joint Military Training (CJMT) Complex (a U.S. Pacific Command (PACOM) initiative (led by USMC) to reduce joint training deficiencies in the Western Pacific); and an Air Force Divert and Exercise Field on Tinian.

PACOM requires a Joint Military Training Complex in-theater to meet Department of Defense training requirements in the theater. The Complex will make a key contribution to the readiness of Marines relocating to Guam and provide bilateral and multilateral training opportunities with foreign allies and partners. The Department sought to design the CJMT complex on Tinian and Pagan in a manner that minimizes the impacts on the local communities and provides direct economic and other benefits while meeting PACOM and its Service Components' training requirements.

The training complex includes a series of live-fire Range Training Areas, training courses, maneuver areas, and associated support facilities located in close proximity to each other. The total cost of the complex is ~$900 million with GoJ contributing $300 million. In April 2015, the Department of Navy (DON) released the draft Environmental Impact Statement (DEIS) for the proposed action with an original public comment period of 60 days (extended to 180 days to accommodate requests by the CNMI Governor to give him more time in light of Internet problems and damage from Typhoon Soudelor). In response to the over 28,000 comments received in October 2015 the DON announced its intent to prepare a Revised DEIS to more fully address potential impacts to water, coral, and other natural resources. The DON now estimates the ROD will be issued in the summer of 2018. This timeline still supports force flow to Guam in 2022.

The Air Force needs to establish a divert capability for up to 12 tankers if access to Andersen Air Force Base is unavailable. The Air Force proposes to construct facilities and infrastructure to support a combination of cargo, tanker, and similar aircraft and associated personnel not only for divert operations, but also to support periodic exercises and disaster relief activities. Efforts to establish this capability are on track for a Record of Decision in mid-April 2016. The Air Force is now pursuing a Tinian-only solution consistent with CNMI's desires.

BUILDING AND MAINTAINING RESILIENCE IN THE FACE OF A CHANGING CLIMATE

Resilience to climate change continues to be a priority for the Department. Both the 2010 and 2014 Quadrennial Defense Reviews (QDRs) discussed the impacts associated with a changing climate that present a threat to DOD's national security mission. We recognize these impacts and their potential threats represent one more risk that we must consider as we make decisions about our installations, infrastructure, weapons systems and, most of all, our people. We have always dealt with the risks associated with extreme weather events and its impacts on our operations and missions. Our challenge today is how to plan for changes in the environment we will be operating from and in.

Even without knowing precisely how or when the climate will change, we know we must build resilience into our policies, programs, and operations in a thoughtful and cost effective way. In January 2016, we issued a DOD Directive on climate change adaptation and resilience that identifies roles and responsibilities across the Department for implementing these strategies over the next 10 years.

Specifically, I am focusing on our installations and infrastructure. Sea level is rising and many coastal areas are subsiding or sinking. This impacts the operation and maintenance of our existing installations and infrastructure. As Arctic Sea ice melts and breaks apart, our early warning radar sites are being eroded away at a much greater rate than before. Drought and flooding, which ironically go together, threaten water resources for us and our surrounding communities and exacerbate wildfire issues across the country.

The Military Services have conducted a screening level assessment of all DOD sites world-wide to identify where we are potentially vulnerable to extreme weather events and tidal anomalies today. The information gleaned from this initial look will help to focus reviews of installation footprints, and shape planning for current and future infrastructure.

Given the projected increases in major storms, DOD continues its progress to ensure energy resilience for its military installations. We completed our power resilience review, and are now updating Department-level instructions to include energy resilience requirements. These requirements will ensure that the Department has the ability to prepare for and recover from energy disruptions that impact mission assurance on its military installations.

Our goal is to increase the Department's resilience to the impacts of climate change. To achieve this goal, we are integrating consideration and reduction of climate risks into our already established mission planning and execution.

FINANCIAL IMPROVEMENT & AUDIT READINESS

In order to effectively manage its financial resources, the Department remains focused on improving financial record keeping and conducting an independent audit of DOD's financial books beginning in fiscal year 2017. This includes not only an audit of the Department's Statement of Budgetary Resources, but also validating the existence and completeness, rights and obligations, and financial valuation of slightly less than 562,000 facilities located at 513 installations world- wide. The results of a more accurate and reliable real property inventory will better inform our decisions and actions in addressing our real property management challenges.

The Department has made significant progress towards the environmental liabilities associated with our cleanup program and disposal of equipment aspects of the financial audit. Last fall we issued clarifying policies through which we are refining the cost estimates associated with those liabilities; thereby giving the Department a better understanding of our future environmental costs and the ability to plan for any required remediation.

MISSION COMPATIBILITY EVALUATION PROCESS

The Department appreciates the legislative changes made in fiscal year 2016 to section 358 of the Ike Skelton National Defense Authorization Act of Fiscal Year 2011. These changes significantly streamlined the Mission Compatibility Evaluation Process, and ensured that DOD's mission capabilities are protected from incompatible energy developments. As a result of congressional direction and our own efforts we are effectively evaluating the mission impact of utility-scale energy projects, while being mindful of the need for a clean energy future. In 2015 the Department reviewed over 3,400 applications for energy projects that were forwarded by the Federal Aviation Administration. The DOD Siting Clearinghouse worked aggressively with the Military Departments, energy project developers, and relevant States to implement affordable and feasible mitigation solutions where DOD missions might have been adversely impacted. No project reviewed in 2015 rose to the level of an unacceptable risk to the national security of the United States, which is the threshold established in Section 358 of the fiscal year 2011 NDAA to object to a project. The Department is prepared for an increased number of renewable energy project developments as newly approved tax credits become available to developers.

CONCLUSION

Thank you for the opportunity to present the President's fiscal year 2017 budget request for DOD programs supporting installations, energy, and the environment. Our budget situation requires that we take risk in our facilities. No one is happy about that, but we are effectively managing within this budget constrained environment and we appreciate Congress' continued support for our enterprise and look forward to working with you as you consider the fiscal year 2017 budget request.

Senator KIRK. Thank you.

DEPARTMENT OF THE ARMY

STATEMENT OF HON. KATHERINE HAMMACK, ASSISTANT SECRETARY OF THE ARMY, INSTALLATIONS, ENERGY, AND ENVIRONMENT

Ms. HAMMACK. Good morning, Chairman Kirk, Ranking Member Tester, and distinguished members of the subcommittee. I am here to present the Army's fiscal year 2017 budget for Installations, Energy, and Environment.

Chairman Kirk, to your comment on how this supports combatant commanders of the Army's military construction (MILCON) budget (of the Army's budget of about $1 billion), a little over 28 percent supports combatant commanders' requirements.

And our budget is at historic lows. We haven't seen this low of a budget since 1993. It is an 18-percent reduction from last year's budget.

To Pete Potochney's comments, we are struggling in an era with very low toplines, and the Army has decided to take strategic risk in funding installations, so that we can support soldier readiness.

Twenty-three percent of our MILCON request goes to the National Guard. It is about $233 million. That is to support readiness centers as part of the total force strategy.

The National Guard put together a readiness center transformation master plan, which identifies that there are critical facility shortfalls. Those are not only in the National Guard, but they are across the Army. Our budget addresses some of the shortfalls

in the National Guard. It is a step toward achieving the objectives they identify.

But the National Commission on the Future of the Army, a report that was issued in January, identifies that Congress and the administration should look for cost saving opportunities in areas such as energy savings and reduced inventory of military facilities.

So with the planned reductions in the Army in force structure, we will have an excess of 21 percent. If the Army has to get smaller, our excesses will only increase.

So therefore, I echo Mr. Potochney's request for a BRAC authorization. The Army estimates that it could save over $500 million annually, and that is money that we could invest in training. That is money that we could invest in force structure to ensure that we can support this Nation the way we need to.

Without a BRAC, we continue to spend scarce resources to maintain unneeded infrastructure or underutilized infrastructure. I believe this is an unacceptable result for the Army and a disservice to the American taxpayer, so I look forward to working with Congress to help shape a future BRAC round.

We are focused on energy efficiency. We have seen a reduction in our energy consumption by over 22 percent in the last 10 years. We have a focus on renewable energy, and our renewable energy program is primarily funded with private-sector capital where we are leveraging the private sector to install renewable energy systems on our bases at no cost to the Army, and we are going to see over $250 million savings in projects already identified.

At the same time, we have over 12 million acres of land that have historic characteristics, and over 200 endangered species. That requires a little over $1 billion to ensure that we are meeting our environmental requirements, so that the Army can train and test the way that is needed.

But the Army's top priority remains readiness. So this budget is focused on ensuring we can get as much readiness as possible out of limited dollars, but supporting the soldiers and trying to get them the quality of life that they require.

Thank you for the opportunity to appear before you today and I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF HON. KATHERINE G. HAMMACK

INTRODUCTION

Chairman Kirk, Ranking Member Tester, and members of the subcommittee: on behalf of the soldiers, families, and civilians of the United States Army, thank you for the opportunity to present the Army's fiscal year 2017 budget request for Installations, Energy, Environment, and Base Realignment and Closure.

The U.S. Army's top priority continues to be readiness: the Army must be ready to shape the global security environment, defend our homeland, and win the Nation's wars. To meet these missions, the Army requires ready and resilient installations—our power projection platforms—to enable regional engagement and global responsiveness. Our fiscal year 2017 budget request reflects the Army's decision to take risk in our installation facilities and services to maximize available funding for operational readiness and modernization. The request focuses our limited resources on necessary and prudent investments in military construction, installation energy programs supporting operational activities, and environmental compliance.

The Army recognizes that reduced funding of installations accounts will lead to the continued degradation of our facilities and infrastructure, and risks our long-term ability to adequately support Army forces and meet mission requirements. The

Army is stretched thin at a time when we are facing a global security environment that is more uncertain than ever. Without increased funding in the outyears or the authority to close and realign our installations, these problems will only get worse—expending precious funds and putting the readiness and welfare of our soldiers at risk. It is therefore particularly critical that we maximize the efficient use of our resources at this time to meet mission requirements and ensure soldier readiness.

The Army's fiscal year 2017 military construction appropriations request strikes a careful balance to meet these growing and changing demands. We look forward to working with Congress to ensure that our national security needs and priorities are met in the upcoming fiscal year and well into the future.

MAKING EFFICIENT USE OF ARMY FACILITIES

To meet readiness requirements, the Army must maintain installations that make efficient and effective use of available facilities. Army installations should be sized and resourced to meet the needs of our current and future missions, both at home and overseas.

Efficient use of our installations includes the closure of low military value installations and the divestment of excess facilities that burden Army budgets. Reducing the portfolio of Army facilities was among the recommendations of the National Commission on the Future of the Army (NCFA), established by Congress as part of the fiscal year 2015 National Defense Authorization Act (NDAA). The NCFA's report, released in January 2016, states that "Congress and the Administration should look for cost-saving opportunities in areas such as . . . a reduced inventory of military facilities." [1] The report recommends that the Army pursue these and other efficiency initiatives to free up funds that could be used to meet warfighting needs and other high-priority initiatives identified by the Commission.

The Army has made every effort to be fiscally prudent in the maintenance of excess infrastructure. The Army has employed its current authority to minimize costs and maximize the use of existing facilities. We have identified and are working to reduce excess capacity overseas through the European Infrastructure Consolidation (EIC) initiative, in addition to implementing efficiency measures across the board. Nevertheless, the modest savings attained from these efforts cannot substitute for the significant savings that can be achieved through base realignments and closures. Without them, the Army is forced to make deep cuts at our highest military value installations because we continue spending scarce resources maintaining and operating lower military value installations.

As the Army is planning to reduce its Active Component end strength to 450,000 by fiscal year 2018, we will have over 170 million square feet of facilities that are not fully utilized—an excess facility capacity averaging 21 percent. Depending on the facility type, the excess infrastructure ranges from 18 percent to 33 percent. At an annual cost of about $3 per square foot to maintain these facilities, the Army is incurring over $500 million a year in unnecessary expenditures. If fiscal year 2018–2021 budget caps remain, the Army will need to further reduce the number of soldiers, and our excess capacity will continue to increase.

The Army cannot afford this status quo. Although Base Realignment and Closure (BRAC) forces difficult choices affecting the local communities surrounding our installations, they are already seeing fewer and fewer soldiers and families as force structure continues to decline. BRAC allows the Army to use a fair and non-partisan process to close a few lower military value locations and realign the remaining missions to help fill the excess capacity at our higher military value installations.

Not authorizing BRAC is still a choice with real consequences. The lack of authorization for a BRAC results in our highest military value installations bearing the deepest impacts. This is an unacceptable result for the Army and a disservice to American taxpayers.

Facilities needed to support readiness, training exercises, airfields, and other priorities are deteriorating, while resources are diverted to supporting installations that could be closed. The Army cannot carry excess infrastructure costing over half a billion dollars per year indefinitely. Half a billion dollars represents the annual personnel costs of about 5,000 soldiers, which is slightly less than the number assigned to a Stryker Brigade Combat Team. It represents five annual rotations at the Army's Combat Training Centers, which are the foundation of Army combat readiness.

Until we get the BRAC authority to analyze what types of excess exist at individual installations and develop recommendations on how to best consolidate into

[1] National Commission on the Future of the Army, "Report to the President and Congress of the United States," 28 January 2016, p. 44: Recommendation 5.

the highest military value installations we have, we do not know which lower military value installations should be closed and/or realigned. However, we do know BRAC is a proven process producing significant reoccurring savings of roughly $2 billion per year for the Army, as validated by the Government Accountability Office (GAO). A future BRAC round has the capability to save the Army hundreds of millions of dollars per year. Once the up-front costs are paid, the intermediate and long-term savings from BRAC can fund any number of important Army warfighter initiatives, including force structure, additional CTC rotations, and modernizations.

The BRAC process is a proven, cost-effective means for reducing costly excess infrastructure, while ensuring a continued focus on efficiency and consolidation. The Army strongly supports DOD's request for a BRAC round, and urges Congress to enact legislation in fiscal year 2017 authorizing the Department to begin the process.

PRESERVING READY INSTALLATIONS

Army installations—where soldiers live, work, and train—are where Army readiness is built to meet future challenges and ensure the security of our Nation. Increasing global threats generate installation requirements for force protection, cyber security, and energy security. Installation budgets provide the premier all-volunteer Army with facilities that support readiness and quality of life for our soldiers, families, and civilians.

The Army continues to focus its limited resources on supporting readiness initiatives and replacing failed facilities. As we remain under pressure from current law budget caps, our installation services must continually be adjusted. Increases in deferred maintenance and reduced investments in installations and infrastructure ultimately increase our growing backlog of failing facilities. This degrades the Army's ability to be ready to project full spectrum forces over time. Excess facility capacity burdens the Army sustainment and base operations—consuming limited dollars that need to be better invested elsewhere.

Sustainment, Restoration, and Modernization (SRM) accounts fund investments to maintain and improve the condition of our facilities. Periodic restoration and modernization of facility components are necessary to ensure the safety of our soldiers and civilians. Efforts are focused on preventing the degradation of our facilities and optimizing the use of Army investments, to prevent small maintenance issues from turning into large and expensive problems.

The fiscal year 2017 $3.1 billion budget request will help support our sustainment and restoration requirements. However, the Army is assuming risk in installation readiness to preserve operational readiness. The $2.7 billion request for Sustainment meets 71 percent of our Facility Sustainment Model for long-term sustainment, whereas DOD recommended meeting an 80 percent threshold to stem the tide of further facility degradation.

Reduced funding in the outyears for installation readiness adversely impacts facility condition and ultimately increases future military construction and restoration and modernization requirements. This shifts the Army's investment focus to the worst facilities, diverting resources needed to preserve our newest and best infrastructure. Deferred sustainment over the long term can lead to higher life-cycle repair costs and component failure, significantly reducing facility life expectancy.

Responsibly managing over 12 million acres of real property also means that the Army must maintain extensive base operations. Through funding for Base Operations Support (BOS) accounts, Army installations provide services similar to those associated with a municipality: public works, security protection, logistics, environment, and Family programs. These programs and services enable soldiers, civilians, and families to live and work on 154 Army installations worldwide.

Balancing BOS needs in a changing global environment calls for continued due diligence. The President's fiscal year 2017 budget therefore requests a total of $9.43 billion for BOS accounts, including $7.82 billion for the Active Component; $1.04 billion for Army National Guard; and $573.8 million for Army Reserve.

INVESTING IN ESSENTIAL INFRASTRUCTURE

The Army's request for Military Construction provides secure and sustainable facilities and infrastructure critical to supporting the Combatant Commander's top priorities, enabling Army missions, and maintaining soldier and unit readiness. For fiscal year 2017, the Army requests just over $1 billion for Military Construction, a reduction of $229 million—18 percent—from fiscal year 2016 appropriations. The budget allocates $503 million (approximately 50 percent) for the Active Component; $233 million (23 percent) for the Army National Guard; $68 million (7 percent) for

Army Reserves; and $201 million (20 percent) for Army Family Housing Construction.

The Army continuously reviews project scope and costs. We must continue to adapt to evolving missions, account for emerging organizational changes, and meet unit readiness needs, while simultaneously seeking efficiencies at every opportunity. However, funding for Army Military Construction has reached historically low levels. This reduces the Army's ability to recapitalize inadequate and failed facilities into infrastructure that supports operations, readiness, and the welfare of the all-volunteer force.

The Army National Guard (ARNG) is the oldest component of the U.S. Armed Forces. The Guard has courageously participated in every war and every conflict this Nation has ever fought, including Iraq and Afghanistan, and is our first line of defense in responding to domestic emergencies. These men and women perform an important mission for our country, and our military construction budget endeavors to ensure that the needs of their facilities are met.

The Guard's fiscal year 2017 Military Construction request is $232.9 million. This includes $161.3 million to support seven Readiness Centers, $50.9 million to construct three maintenance facilities, $12 million to fund minor projects, and $8.7 million for planning and design. Our ARNG budget request is focused on recapitalizing readiness centers—the heart and soul of the National Guard—as well as maintenance facilities, training areas, ranges, and barracks to allow the Guard to be ready to perform State and Federal missions. These projects will address space constraints and focus on replacing failing facilities.

In the 2014 ARNG Readiness Center (RC) Transformation Master Plan, a key finding was that the RC portfolio is experiencing "critical facility shortfalls." This budget request is a small step toward addressing the ARNG's challenges.

The fiscal year 2017 budget request for the Army Reserve totals $68.2 million, with four critical projects totaling $57.9 million. Three of these will focus on replacing some of our most dilapidated and failing facilities on Army Reserve installations that are in the most dire need. This includes $21.5 million to replace an Emergency Services Center at Fort Hunter Liggett, California—currently in failing condition—which will provide life-saving police, fire, crash and rescue, and Emergency Medical Team (EMT) services. An additional $10.3 million will support planning and design of future year projects, as well as to address unforeseen critical needs through the Unspecified Minor Military Construction account.

The Army Family Housing budget allows us to provide homes and services to the soldiers and their families living on our installations around the world. For fiscal year 2017, the Army requests $200.7 million for family housing construction. This will fund two projects in Korea, at Camp Humphreys and Camp Walker, critical to supporting consolidation and quality of life for our soldiers and their families. The projects are necessary to eliminate dilapidated family housing units and meet the U.S. Forces Korea (USFK) Commander's requirements for housing. An additional $326 million is requested to help sustain all family housing operations, cover utility costs, ensure proper maintenance and repair of Government family housing units, lease properties where advantageous, and provide privatization oversight and risk mitigation.

ENSURING ENERGY SECURITY

It is operationally necessary, fiscally prudent, and mission essential that the Army have assured access to the energy required to achieve our primary objectives for the United States. The Army has led the way toward increasing energy efficiency on our installations, harnessing new energy technologies to lessen soldier battery loads, and improving our operational capabilities to reduce the need for fuel convoys. Our installation energy budget request is focused on enhancing mission effectiveness, and is supported by strong business case analyses. For fiscal year 2017, the Army is requesting $1.716 billion to pay utility bills on our installations, leverage private sector investment in renewable energy projects, and invest in discrete energy efficiency improvements.

In response to risks posed to our vulnerable energy grid, the Army is improving the "resiliency" of its installations through the use of on-base renewable sources of energy. A resilient Army installation is one that can withstand threats to its security—be they power interruptions, cyber-attacks, or natural disasters—and endure these hazards to continue its own operations and those of the local community. With this in mind, the Army conducted a test and temporarily disconnected Fort Drum, New York from the energy distribution network this past November, validating the installation's ability to operate independently from the wider grid.

The Army leads the Federal Government in the use of Energy Savings Performance Contracts (ESPCs) and Utility Energy Service Contracts (UESCs), which allow private companies and servicers to provide the initial capital investment needed to execute projects using repayments from Utilities Services Program savings. The amount of energy saved by Army ESPC and UESC projects awarded between fiscal year 2010 and fiscal year 2015 is equal to the amount of energy consumed by Fort Bragg—one of the Army's largest and most populous installations—in a year. In total, the Army has reduced its facilities energy consumption by 22.6 percent since fiscal year 2003, while also leading the Federal Government in reductions of its potable water intensity use and non-tactical vehicle (NTV) fossil fuel use.

In addition, our energy program account funds the Office of Energy Initiatives (OEI), which helps to plan and develop third party-financed renewable energy projects. OEI currently has 14 projects completed, under construction, or in the final stages of the procurement process—together providing an incredible 350 megawatts (MW) of generation capacity. These projects represent over $800 million in private sector investment, saving funds that would otherwise be appropriated for military construction. Further, all of these projects provide electricity that is at or below the cost of conventional power.

The Army's operational energy initiatives provide extended range and endurance, increased flexibility, improved resilience, and force protection, all while enhancing mobility and freedom of action for our soldiers. Operational energy investment in science and technology has been a proven force multiplier, providing our soldiers with a distinct advantage on the battlefield. Therefore, the bulk of our operational energy budget request, $1.28 billion, is for investments in energy efficient equipment by the Army acquisition community that will reduce physical and logistical burdens on our soldiers and, most importantly, help save lives.

The Army's energy program has proven results—reducing our reliance on the grid, improving energy security and efficiency, and contributing to mission readiness—all at a minimal impact to Army budgets. Energy performance on our installations is a testament to the Army's success in leveraging its limited resources to achieve considerable results. We urge Congress to continue to support the Army's energy initiatives both in operational and installation environments.

SAFEGUARDING OUR ENVIRONMENT

The mission of the Army's environmental program is three-fold: (1) to comply with environmental laws and regulations and ensure proper stewardship of our natural, cultural, and Tribal resources; (2) to meet DOD's goals for installation restoration and munitions response; and (3) to invest in environmental technology research, development, testing, and evaluation.

The Army manages over 12 million acres of land, which requires the Army to protect endangered species and historic sites or structures. Efforts are made to remediate environmental contaminants that pose a danger to human health or the environment, while supporting Army operations and our soldiers, families, and communities. Our fiscal year 2017 budget request of $1.05 billion will allow the Army to fulfill these objectives, keeping the Army on track to meet our cleanup goals and maintain full access to important training and testing lands, which are integral components of Army readiness.

CONCLUSION

Readiness is the U.S. Army's top priority—there is no other "number one." The Army's fiscal year 2017 Military Construction budget request takes moderate risk to ensure our readiness needs are met by focusing our financial resources where they are needed most.

Maintaining failing facilities and low-military value installations takes money away from critical investments in the readiness of our soldiers and the acquisition of advanced weapons and technology. BRAC allows the Army to optimize installation capacity and achieve substantial savings, freeing up scarce resources that could easily be applied elsewhere.

The strength of the U.S. Army is its people, and our installations serve as the platforms for this strength. Without ready and resilient installations, our soldiers will be ill-equipped to fight the growing threats facing our Nation. We owe it to our men and women who wear the Army uniform to be prudent in the use of our installation budgets and prioritize them appropriately to ensure they have the best resources available to defend our homeland.

Thank you for the opportunity to present this testimony and for your continued support of our soldiers, families, and civilians.

Senator KIRK. Thank you.

DEPARTMENT OF THE NAVY

STATEMENT OF STEVEN R. ISELIN, PRINCIPAL DEPUTY ASSISTANT SECRETARY OF THE NAVY, ENERGY, INSTALLATIONS, AND ENVIRONMENT

Mr. ISELIN. Good morning, Chairman Kirk, Ranking Member Tester, members of the subcommittee. I am Steve Iselin. I am the Principal Deputy for Energy, Installations, and Environment for the Department of the Navy and I am pleased to provide this overview of our energy infrastructure and environmental programs.

Navy and Marine Corps installations and facilities are platforms for preparing marines and sailors; for deploying ships, aircraft, and operational forces to meet their mission requirements; and for supporting military families.

The President's fiscal year 2017 budget requests $11.9 billion to operate, maintain, and recapitalize these installation platforms. That is about 10 percent less than the fiscal year 2016 levels.

The Department, including the senior leaders of the Department, realize this funding level impacts long-term ownership costs and is mindful that continued funding at these levels will cause degradation and future operational impacts.

Importantly, though, over the last few years, the Department has significantly improved its condition assessment process and its risk-based strategy to ensure the money we do get supports the most critical projects.

The following are a few specifics from this year's request.

The request includes $1.1 billion for military construction to support warfighting requirements and to modernize some utility and critical infrastructure. It is a 35-percent reduction from fiscal 2016 levels. And separately, the Department provided an unfunded priority list that includes other priority military construction projects that were unaffordable within the available budget authority.

The request includes $1.9 billion for facility sustainment, restoration, and modernization, also a decrease from last year's levels. This funds Navy sustainment at 70 percent and Marine Corps sustainment at 74 percent of the Department of Defense (DoD) sustainment model.

We are continuing to carefully accept risk and recognize that continued funding below these amounts will also cause our portfolio to deteriorate. The unfunded priority list also includes additional sustainment and restoration funding this year.

The budget requests $7.6 billion for base operation support. That is about the same level as last year. And both the Navy and Marine Corps consciously invest at a level necessary to meet minimum acceptable standards in how we operate and maintain our facilities.

The request includes $1 billion to meet environmental program statutory and stewardship responsibilities. We take our environmental stewardship responsibilities seriously and are really proud of our record in environmental planning, compliance, and cleanup, and in our efforts to be good stewards of cultural, natural, and historic resources.

The Navy and Marine Corps energy programs have two central goals, first, enhancing combat capabilities, and second, advancing

energy security. Like the other services, we have partnered with other government agencies, academia, and, importantly, the private sector, and we are achieving these goals with the same spirit of innovation that has marked our naval history.

I must also say that I am very proud of the many dedicated professionals who over the last 5 years have persevered despite furloughs, pay and hiring freezes, limited awards and rewards, reduced budgets, and restrictions on travel and training. They have and will continue to effectively manage our Navy and Marine Corps installations, despite the challenges and constraints.

In conclusion, this year's budget request makes the required investments to support current readiness while accepting known risks in the sustainment and modernization accounts. I appreciate the opportunity to testify today. I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF STEVEN R. ISELIN

Chairman Kirk, Ranking Member Tester, and members of the subcommittee, I am pleased to appear before you today to provide an overview of the Department of the Navy's (DON) investment in its infrastructure, energy, and environment programs.

Our Navy and Marine Corps installations and facilities are the platform to train and prepare our marines and sailors, to deploy ships, aircraft and operational forces, as well as to support our military families. We are stewards of a large portfolio of installations—valued at $229 billion ($173 billion Navy and $56 billion USMC, respectively) in plant replacement value—that is vital to our operational forces. Against the backdrop of world events and competing requirements and resources, we must balance our desired level of funding with the principal purposes for our existence: to optimize readiness of the operational forces and preserve their quality of life. Readiness-enablers include runways, piers, operations & maintenance facilities, communications & training facilities, and utilities; those that enable quality of life include barracks, mess halls, and recreation and fitness centers. We have a responsibility to balance the investments for this portfolio according to current year authorizations while being mindful of the impacts to life cycle and ever-evolving mission requirements.

INVESTING IN OUR INFRASTRUCTURE

We thank Congress for passage of the Bipartisan Budget Act (BBA) of 2015, the National Defense Authorization Act (NDAA) for fiscal year 2016 and the Consolidated Appropriations Act, 2016. Although the BBA of 2013 provided some budget stability for fiscal year 2014–2015, and limited relief from the Budget Control Act (BCA) of 2011 sequestration levels, the unfortunate consequence of constrained DON funding levels and timing is that many of our installations' piers, runways, and other facilities are degrading. We continue to make progress in replacing and demolishing unsatisfactory infrastructure, yet still have challenges based on BCA caps and on the prospect of a return to sequestration levels in fiscal year 2018.

In fiscal year 2017, the President's budget (PB) is requesting $11.9 billion in various appropriations, a 10.4 percent decrease ($1.4 billion) from amounts appropriated in fiscal year 2016 to operate, maintain and recapitalize our shore infrastructure. Figure 1 compares the fiscal year 2016 enacted budget and the fiscal year 2017 PB request by appropriation. Each appropriation is discussed more fully in the following sections.

FIGURE 1: DON INFRASTRUCTURE FUNDING BY APPROPRIATION

Appropriation	Fiscal year 2016 enacted ($ millions)	President's budget 2017 ($ millions)	Delta ($ millions)	Delta (%)
Military Construction, Active and Reserve	1,739	1,126	−613	−35.3
Family Housing, Construction	17	94	77	452.9
Family Housing, Operations	353	301	−52	−14.7
BRAC	170	154	−16	−9.4
Sustainment, Restoration and Modernization	3,110	2,356	−754	−24.2
Base Operating Support	7,625	7,610	−15	−0.2

FIGURE 1: DON INFRASTRUCTURE FUNDING BY APPROPRIATION—Continued

Appropriation	Fiscal year 2016 enacted ($ millions)	President's budget 2017 ($ millions)	Delta ($ millions)	Delta (%)
Environmental Restoration, Navy	300	282	−18	−6.0
Total	13,314	11,923	(1,391)	−10.4

Notes:
MILCON, SRM and BOS include OCO
BOS includes BSIT

We strive to maintain a shore infrastructure that is mission-ready, resilient, sustainable and aligned with Fleet and operational priorities. Toward that end, and especially important given the risks inherent at these funding levels, Navy and Marine Corps have taken actions to more proactively manage the installations portfolio. For example, Navy has taken the initiative to:

—Standardize the facility inspection and Facility Condition Index (FCI) process that quantifies facility condition and documents the needed maintenance and repair work within our facilities portfolio. This information helps guide spending of available dollars.
—Incorporate principles of condition-based maintenance across all buildings, utilities and structures, in order to prioritize work on only the most critical components (e.g. roofs and exterior walls) at our most critical facilities or on components that relate to life, health and safety. We are able to focus resources on specific building components and systems where failure jeopardizes personnel safety or a warfighting mission.
—Led by Commander, Navy Installations Command, exercise a single integrated forum to receive and adjudicate demand signals from Fleet and Enterprise Commanders to identify and prioritize projects, optimizing the available resources.
—Maintain focus on reducing footprint by demolishing or divesting unneeded buildings as funds are available, and recapitalizing existing facilities in lieu of new construction when possible.
—Supplement available appropriated dollars by the increased use of authorities that leverage third party financing for improving infrastructure while lowering energy consumption and energy costs.

MILITARY CONSTRUCTION (MILCON)

Navy's MILCON program funds infrastructure at home and abroad, supports our warfighters, and meets the objectives in CNO's Design for Maintaining Maritime Superiority and the Secretary of Defense's Strategic Guidance. Together, Navy and Marine Corps will invest $1.13 billion worldwide in military construction funds to support warfighting and modernization of our utilities and critical infrastructure.

For Navy, the fiscal year 2017 request is for 25 projects, Planning and Design and Unspecified Minor Construction, at a budget of $700 million, which is 29 percent lower than the fiscal year 2016 as-enacted budget of $986 million. Navy has invested an average of $1 billion annually in MILCON since 2010, and the fiscal year 2017 request is the lowest since 1999. Navy continues to invest prudently in MILCON, but assumes long-term risk in deferring recapitalization of our existing infrastructure.

The Navy's fiscal year 2017 MILCON request supports Combatant Commander requirements, enables new platforms/missions, upgrades utilities and energy infrastructure, recapitalizes Naval Shipyard facilities, and supports weapons of mass destruction (WMD) training requirements. They include:

Combatant Commander Support ($233 million, 9 projects):
Medical/Dental Facility—Camp Lemonnier Djibouti
Harden POL Infrastructure—NAVBASE Guam
Coastal Campus Utilities Infrastructure—NAVBASE Coronado
Coastal Campus Entry Control Point—NAVBASE Coronado
Communication Station—NAVSTA Rota
Grace Hopper Data Center Power Upgrades—NAVBASE Coronado
Missile Magazine—NAVWPNSTA Seal Beach
P–8A Hanger Upgrade—NSA Naples (Keflavik, Iceland)
P–8A Aircraft Rinse Rack—NSA Naples (Keflavik, Iceland)

New Platform/Mission ($198 million, 6 projects):
UCLASS RDT&E Hangar—Naval Air Station PAX River

Triton Mission Control Facility—NAS Whidbey Island
Triton Forward Operating Base Hangar—VARLOCS
EA–18G Maintenance Hangar—NAS Whidbey Island
F–35C Engine Repair Facility—NAS Lemoore
Air Wing Simulator Facility—NAS Fallon

Utilities and Energy Infrastructure ($85 million, 4 projects):
Upgrade Power Plant & Electrical Distribution System—PMRF Barking Sands
Energy Security Microgrid—Naval Base San Diego
Service Pier Electrical Upgrades—Naval Base Kitsap
Shore Power (Juliet Pier)—COMFLEACT Sasebo

Naval Shipyards ($76 million, 4 projects):
Sub Refit Maintenance Support Facility—Naval Base Kitsap
Nuclear Repair Facility—Naval Base Kitsap
Utilities for Nuclear Facilities—Portsmouth Navy Shipyard (New Hampshire)
Unaccompanied Housing Consolidation—Naval Shipyard Portsmouth (New Hampshire)

WMD Training ($21 million, 1 project):
Applied Instruction Facility—NAS Whiting Field, Milton, Florida

MILCON Reserves ($11 million, 1 project):
Joint Reserve Intelligence Center—NAS JRB New Orleans

For the Marine Corps, the fiscal year 2017 request is for 11 projects, Planning and Design and Unspecified Minor Construction, at a budget of $426 million, which is 44 percent lower than the fiscal year 2016 as enacted budget of $754 million. Investments in MILCON will primarily support new warfighting platforms, weapons support, force relocation facilities (Rebalance to the Pacific, Aviation Plan), improve security and safety posture, and recapitalize and replace inadequate facilities. The 11 projects in the Marine Corps fiscal year 2017 MILCON budget include:

New Platform and Weapons Support Facilities ($110 million, 2 projects):
F–35 aircraft maintenance hangar at MCAS Beaufort, South Carolina; and
F–35 aircraft maintenance shops at Kadena Air Base, Japan.

Facilities to Support Force Relocations/Increased Force Requirements ($119 million, 3 projects):
Aircraft maintenance hangar for VMX–22–MCAS Yuma;
Expansion of Reserve Center Annex—Galveston; and
Utility upgrades for Finegayan cantonment area—Guam.

Safety, Security, and Environmental Compliance ($31 million, 2 projects):
EPA-required central heating plant conversion—MCAS Cherry Point; and
Range safety improvements at MCB Camp Lejeune.

Recapitalize and Replace Inadequate Facilities ($117 million, 4 projects):
Replace and consolidate communications, electrical, and maintenance shops—MCB Hawaii;
Replace unreliable electrical power supply at reserve center—Brooklyn, New York;
Replace reserve training facilities—Syracuse, New York; and
Modernize recruit barracks and construct a recruit reconditioning center for injured recruits at MCRD Parris Island.

Reduced funding availability in MILCON will result in reduced investments in projects that support the consolidation of functions or replacement of existing facilities, which will cause degradation of the long-term health of existing facilities.

Relocation of marines to Guam remains an essential part of the United States' larger Asia-Pacific strategy of achieving a more geographically distributed, operationally resilient and politically sustainable force posture in the region. Guam provides a critically important forward base for our expeditionary Marine ground and air forces and also provides key sustainment capabilities for our forward-deployed ships and submarines. The permanent basing of marines in Guam significantly contributes to maintaining regional stability and provides reassurance for key allies and partners across the Pacific region.

FAMILY HOUSING

The Department continues to rely on the private sector as the primary source of housing for sailors, marines, and their families. When suitable, affordable, private housing is not available in the local community, the Department relies on

government- owned, privatized, or leased housing. The fiscal year 2017 request of $395 million supports Navy and Marine Corps family housing operation, maintenance, renovation, and construction requirements. Of this amount, $79 million is for the first phase of replacement of inadequate family housing at Naval Support Activity Andersen, Guam and $11 million is for the renovation of family housing at Marine Corps Air Station Iwakuni, Japan. The budget request also includes $301 million for the daily operation, maintenance, and utilities expenses of the military family housing inventory.

To date, over 62,000 Navy and Marine Corps family housing units have been privatized through the Military Housing Privatization Initiative (MHPI). MHPI has enabled the Department to leveraged private sector resources to improve living conditions for sailors, marines, and their families.

FACILITIES SUSTAINMENT, RESTORATION AND MODERNIZATION (FSRM)

To maximize support for warfighting readiness and capabilities, the President's fiscal year 2017 budget request continues to carefully accept risk in FSRM.

The fiscal year 2017 budget requests $1.9 billion to sustain infrastructure, a 16 percent reduction from the fiscal year 2016 enacted value of $2.3 billion. Navy and the Marine Corps have resourced fiscal year 2017 facilities sustainment at 70 percent and 74 percent, respectively, of the Department of Defense (DOD) Facilities Sustainment Model. Over time, this lack of sustainment will cause our facilities to deteriorate.

To restore and modernize our existing infrastructure, the the fiscal year 2017 budget request is $463 million, a 38 percent reduction from the fiscal year 2016 enacted value of $749 million. Budget constraints have compelled the Department to focus its limited resources to address life/safety issues and the most urgent deficiencies at our mission-critical facilities, piers, hangars, runways and utility systems. We are committed to fully funding infrastructure at strategic weapons facilities, accelerating Naval shipyard infrastructure improvements, supporting the Marine Corps Aviation Plan, and force relocations. However, as the Department defers less critical repairs, especially for facilities not directly tied to DON's warfighting mission, certain facilities degrade and the overall facilities maintenance backlog increases. At current funding levels, the overall condition of DON infrastructure will slowly, but steadily, erode over the Future Years Defense Plan (FYDP). Although we are proactively managing the risk we are taking in our shore infrastructure, we acknowledge that this risk must eventually be addressed.

BASE OPERATING SUPPORT (BOS)

The fiscal year 2017 BOS request of $7.6 billion is essentially the same as fiscal year 2016 levels. Similar to the risk taken in our facility investments, the Department is accepting lower standards in base operating support at our installations. Base operations at Navy and Marine Corps installations are funded to the minimum acceptable standards necessary to continue mission-essential services. We have enforced low service levels for most installation functions (administrative support, base vehicles, grounds maintenance, janitorial and facility planning) in order to maintain our commitment to warfighting operations, security, family support programs, and child development. These measures, while not ideal, are absolutely necessary in the current fiscal environment.

SAFETY PROGRAM

Our initiatives are improving the skills of our Safety Professionals directly benefiting over 800,000 personnel (uniformed personnel (Active and Reserve) and civilian) executing diverse, complex missions across the globe. DON's safety program has expanded its global online training resources to ensure the Naval Safety workforce is educated and trained through more effective and modernized cost efficient methods. We are acquiring commercial off-the-shelf information technology tools to enhance our tireless fight to reach our objective of zero mishaps. The Risk Management Information initiative will comprise a streamlined mishap reporting system, data base consolidation, state-of-the-art analytical innovations, and data capabilities to improve our predictive abilities for safer sailors and marines.

MANAGING OUR FOOTPRINT

Base Realignment and Closure (BRAC)

We appreciate the congressional support for additional fiscal year 2016 funds for environmental cleanup at BRAC properties. For fiscal year 2017, the Department has planned to expend $154 million to continue cleanup efforts, caretaker oper-

ations, and property disposal. By the end of fiscal year 2015, we disposed of 94 percent (178,180 acres) of our excess property identified in previous BRAC rounds through a variety of conveyance mechanisms. Of the remaining 6 percent (11,674 acres), the majority is impacted by complex environmental issues. Of the original 131 installations with excess property, Navy only has 17 installations remaining with property to dispose.

Although many tough cleanup and disposal challenges remain from prior BRAC rounds, we have fostered good working relationships with regulatory agencies and local communities to tackle these complex issues and provide creative solutions to support redevelopment priorities.

Compatible Land Use

DON has an aggressive program to promote compatible land use adjacent to our installations and ranges. This program helps Navy and Marine Corps to operate and train in cooperation with surrounding communities, while protecting important natural habitats and species. We conduct Air Installation Compatible Use Zone Studies and Range Area Compatible Use Zone Studies, and provide them to nearby communities for their consideration in the exercise of their land management responsibilities.

A key element of the program is Encroachment Partnering, which involves cost-sharing partnerships with States, local governments, and conservation organizations to acquire interests in real property proximate to our installations and ranges. The Department is grateful to Congress for providing funds for the DOD Readiness and Environmental Protection Integration (REPI) Program. Since 2005, DON has acquired restrictive easements on approximately 91,000 acres.

PROTECTING OUR ENVIRONMENT

The Department is committed to environmental compliance, stewardship and responsible fiscal management that support mission readiness and sustainability, investing over $1 billion across all appropriations to achieve our statutory and stewardship goals. The funding request for fiscal year 2017 is about 2.3 percent less than enacted in fiscal year 2016, as shown in Figure 2:

FIGURE 2: DON ENVIRONMENTAL FUNDING BY PROGRAM

Category	Fiscal year 2016 enacted ($ millions)	President's budget 2017 ($ millions)	Delta ($ millions)	Delta (%)
Conservation	86	93	7	8.1
Pollution Prevention	22	19	−3	−13.6
Compliance	480	485	5	1.0
Technology	36	37	1	2.8
Active Base Cleanup (ER,N)	300	282	−18	−6.0
BRAC Environmental	158	141	−17	−10.8
TOTAL	1,082	1,057	−25	−2.3

The Department continues to be a Federal leader in environmental management by focusing resources on achieving specific environmental goals, implementing efficiencies in our cleanup programs and regulatory processes, proactively managing emerging environmental issues, and integrating sound policies and lifecycle cost considerations into weapon systems acquisition to achieve cleaner, safer, more energy-efficient and affordable warfighting capabilities without sacrificing operational capability.

In fiscal year 2017 we will complete environmental planning for Navy's Records of Decision (RODs) for EA–18G Growler training at Whidbey Island, Washington. As an example of our land stewardship responsibilities, we will complete natural and cultural surveys to support Marine Corps air and ground training at Twentynine Palms, California. To maintain our environmentally responsible operations at sea, we will continue to be leaders in ocean research by studying marine mammal behavioral response to sound in water. We will also build on our accomplishments this past fiscal year, which included finalizing the environmental planning processes for the new Marine Corps Base on Guam; completing a 5 year authorization for testing and training in the Marianas Island Testing and Training area with National Marine Fisheries Service; and successfully rearing 500 hatchlings and releasing 35 mature tortoises with the University of California, Los Ange-

les (UCLA) at the Marine Corps Twentynine Palms Desert Tortoise Head Start Facility.

ENHANCING COMBAT CAPABILITIES

The Department of the Navy's Energy Program has two central goals: (1) enhancing Navy and Marine Corps combat capabilities, and (2) advancing energy security afloat and ashore. Partnering with other government agencies, academia and the private sector, we strive to meet these goals with the same spirit of innovation that has marked our history—new ideas delivering new capabilities in the face of new threats.

Our naval forces offer us the capability to provide power and presence —to deter potential conflicts, to keep conflicts from escalating when they do happen, and to take the fight to our adversaries when necessary. Presence means being in the right place, not just at the right time, but all the time; and energy is key to achieving that objective. Using energy more efficiently allows us to go where we're needed, when we're needed, stay there longer, and deliver more firepower when necessary.

Improving our efficiency and diversifying our energy sources also saves lives. During the height of operations in Afghanistan, we were losing one marine, killed or wounded, for every 50 convoys transporting fuel into theater. That is far too high a price to pay. Reducing demand at the tip of the spear through energy efficiency, behavior change and new technologies takes fuel trucks off the road.

I'll mention just a couple of examples. The work that the Marine Corps is doing to integrate solar power and software into autonomous UAVs will allow them to take advantage of environmental conditions and provide persistent surveillance for periods far in excess of our current capabilities without refueling. They are also working on technologies that harvest kinetic and other forms of energy into an integrated power system capable of running a marine's radios and electronic gear. These are real combat capabilities that will result in increased lethality.

Navy is pursuing similar combat capabilities. In 2016 we will begin installing hybrid electric drives in our destroyers, enabling our ships to remain on station longer during low speed missions and extend time between refueling. This is the same technology that is now onboard USS *MAKIN ISLAND* and USS *AMERICA,* allowing those ships to stay on station between refueling far longer than their predecessors.

Improving Energy Security and Resilience

Reliable and affordable electricity at our installations is critical to mission effectiveness. Measures to reduce vulnerability and to increase resiliency of the electrical system improve and protect national security. The 2013 attack on key grid infrastructure in California is a reminder of how fragile the commercial system can be. The Department of the Navy recognizes this vulnerability and is working to enhance our energy security.

Navy's Renewable Energy Program Office (REPO) has brought one gigawatt (GW) of renewable energy into procurement. We expect those renewable energy projects to yield hundreds of millions in projected utility cost savings and even more important energy security benefits. For example, last August we celebrated the procurement of 210 megawatts (MW) of solar generation for 14 installations in California, with a projected cost savings of $90 million over a 25-year term. At Naval Submarine Base Kings Bay, Georgia Power Company is constructing a 42 MW solar generation facility, which the base will have access to during external grid outages. Marine Corps Logistics Base Albany will receive access to a 44 MW on-base solar generation facility for use during grid outages and a second feeder line from Georgia Power Company's grid.

DON's successful industry partnerships form a foundation for future third party-financed energy resiliency projects in the form of microgrids, battery storage, fuel cells, and distributed generation, where these capabilities make sense. Industry has shown interest in battery storage by proposing facilities located at two Navy installations in California. The Arizona Power Service recently signed an agreement to develop a microgrid at Marine Corps Air Station Yuma and will provide the base unlimited access to onsite backup power, eliminating the need for up to 41 diesel generators. These and future energy security efforts using existing Title 10 authorities will help make DON's installations more energy secure and resilient mission platforms.

Strategic Investments in the Future

We endeavor to make investments that enhance our operational flexibility. Our program to test and certify emerging alternative fuels is critical for us to keep pace with developments in the private sector and maintain interoperability with commercial supply chains. In addition, the Defense Logistics Agency (DLA) Energy (through

which Navy buys operational fuels) recently awarded a contract to provide us with an alternative fuel blend of F–76—the fuel we use to power our ships. The contract was awarded at a cost competitive rate with traditional fossil fuels and represents an important step toward diversifying our fuel supply chains.

CONCLUSION

Navy-Marine Corps Energy, Installations and Environment team will continue to carefully and deliberately manage our portfolio to optimize mission readiness, and improve quality of life. The Department's fiscal year 2017 request makes needed investments in our infrastructure and people, preserves access to training ranges, and promotes environmentally prudent and safe actions, while ensuring energy resiliency and security.

Thank you for the opportunity to testify before you today. I look forward to working with Congress to deliver an innovative, resilient, sustainable and secure shore infrastructure that enables mission success for the United States Navy and Marine Corps, the most formidable expeditionary fighting force in the world.

Senator KIRK. Thank you.

Let me ask, Katherine, you talked about strategic risks with the Army. I will show you what I regard as the face of strategic risk at Al Udeid Air Base, which we all call in the military the Deid.

If you could take a look, these pictures were taken by a guardsman, and they have gone somewhat viral on Facebook. I want to make sure that our men and women in uniform are not facing mold contamination like this.

When you talk about strategic risk, that is a very bureaucratic way of saying that this is what you would stick our soldier to live in.

Ms. HAMMACK. One of the challenges that I am sure Secretary Ballentine will talk about is that the Air Force, just like the Army, is not funded to 100 percent of our sustainment requirements.

SUSTAINMENT FUNDING

The Navy just talked about being funded at around 73 percent. The Army is at 71 percent. I know that the Air Force is facing challenges.

When we have known problems, we work to address them and identify resources or reprioritize resources. It is a challenge that all services are facing, to keep up with the environmental requirements.

Senator KIRK. Thank you.

DEPARTMENT OF THE AIR FORCE

STATEMENT OF HON. MIRANDA A.A. BALLENTINE, ASSISTANT SECRETARY OF THE AIR FORCE, INSTALLATIONS, ENVIRONMENT, AND ENERGY

Ms. BALLENTINE. Good morning, Mr. Chairman. Chairman Kirk, Ranking Member Tester, esteemed members of the subcommittee, it is a great pleasure and honor to represent America's airmen before you today.

The bottom line is the Air Force installations are too big, too old, and too expensive to operate. Twenty-four years of continuous combat in a fiscal environment constrained by the Budget Control Act have truly taken their toll.

In order to afford other Air Force priorities, like our sister services, our total fiscal year President's budget 2017 facilities budget at $8.3 billion is down 4 percent from last year, including

MILCON, facilities sustainment, restoration and modernization (FSRM), housing, BRAC, and environmental programs.

The Air Force has prioritized MILCON over FSRM in fiscal year 2017, requesting $1.8 billion in MILCON, that is a 14-percent increase over last year, and $2.9 billion in FSRM, which is down about 10 percent compared to last year.

I expect the backlog of degrading facility requirements to grow.

Our MILCON program is three-tiered. First, MILCON to support combatant commander requests is about 16 percent of the MILCON budget. Second, 34 percent of the fiscal year 2017 MILCON program ensures that we have the infrastructure to support new weapons systems beddown. Third, about 40 percent of the fiscal year 2017 MILCON request allows us to chip away at the very significant backlog of existing mission infrastructure recapitalization needs.

In fiscal year 2017, we funded only about 30 projects of the 500 top priority projects that our commanders submitted.

Let me briefly address Air Force energy programs. The Air Force is focused on mission assurance through energy assurance. We are taking a holistic enterprise approach to installation energy with an emphasis on resilient cost-competitive, cleaner power. The Air Force is also developing, acquiring, and improving aviation energy technologies and behaviors to improve the range and endurance of our weapons systems.

Finally, the Air Force needs another round of base realignment and closure. We have about 30 percent excess infrastructure capacity. Since the Gulf War, we have reduced combat coded fighter squadrons from 134 to 55, a nearly 60-percent reduction. Yet, all BRACs in that time period have only reduced U.S. Air Force bases by 15 percent.

BRAC is not easy, and Congress has shared three very specific concerns.

First, communities. Air Force communities are some of our greatest partners. The Association of Defense Communities recently asked community leaders what they thought about BRAC. About 92 percent said that they believe the status quo of hollowed-out bases, reduced force structure, and reduced investments is worse for their communities than another round of BRAC—92 percent.

Without BRAC, many communities will continue to suffer the economic detriment of hollowed-out bases without the economic support that BRAC legislation provides.

Second, cost. Congress rightly wants to ensure that the savings of BRAC justify the costs, and, of course, we agree. Simply put, the results of BRAC have been staggering.

Previous rounds of BRAC saved the Air Force $2.9 billion each and every year, and the Air Force supports new BRAC legislation that emphasizes recommendations that yield net savings within 5 years.

Third, mission. Some have questioned the wisdom of rightsizing infrastructure to our current force structure. I want to assure you that we have no intent to close infrastructure that may support future needs. Through five previous rounds of BRAC and numerous force structure changes, we have always left the room for future maneuvering, and we always will.

We will continue to leverage community partnerships, enhanced use leases, power purchase agreements, but we really need BRAC authority to get at those significant savings.

In closing, the Air Force made hard strategic choices during the formulation of this budget request in attempting to strike that delicate balance between a ready force for today and a modern force for tomorrow. We believe it is the right way ahead.

Chairman Kirk, Ranking Member Tester, and esteemed members, I request your support for the fiscal year 2017 MILCON request. Thank you, and I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF HON. MIRANDA A. A. BALLENTINE

INTRODUCTION

Ready and resilient installations are a critical component of Air Force operations. Unfortunately, 24 years of continuous combat, a fiscal environment constrained by the Budget Control Act (BCA), and a complex security environment have taken their toll on Air Force infrastructure and base operations support investments. Furthermore, the Air Force is currently maintaining installations that are too big, too old and too expensive for current and future needs. This forces us to spend scarce resources on excess infrastructure instead of operational and readiness priorities.

Air Force installations are foundational platforms comprised of both built and natural infrastructure. Our installations serve as the backbone for Air Force enduring core missions delivering air, space and cyberspace capabilities; sending a strategic message to both allies and adversaries signaling commitment to our friends and intent to our foes; foster partnership-building by stationing our airmen side-by-side with our Coalition partners; and enable worldwide accessibility when our international partners need our assistance and, when necessary, to repel aggression. Taken together, these strategic imperatives require us to provide efficiently operated, sustainable installations to enable Air Force core missions.

The total Air Force fiscal year 2017 facilities budget request is down 4 percent from fiscal year 2016 at $8.5 billion including Military Construction (MILCON), Facility Sustainment, Restoration and Modernization (FSRM), Housing, BRAC implementation and Environmental programs. As in fiscal year 2016, the fiscal year 2017 President's budget (PB) request for the Air Force attempts to strike the delicate balance between a ready force today and a modern force for tomorrow while also continuing its recovery from the impacts of sequestration and adjusting to sustained budget reductions. The result is the Air Force facilities budget accepts near term risk in the entire infrastructure Maintenance and Repair portfolio of MILCON and Sustainment, Restoration and Modernization accounts in order to protect readiness and maintain credible capabilities in other core missions. In doing so, it acknowledges this choice will have long term effects on the overall health of infrastructure.

The Air Force's fiscal year 2017 President's budget includes $1.8 billion in Military Construction (MILCON) requirements, a 14 percent increase over the fiscal year 2016 President's budget. This allows the Air Force to replace degraded facilities that can no longer wait, while still meeting Combatant Commander (COCOM) needs and new weapon systems beddown requirements that must be accomplished now. This also allows us to provide an equitable distribution of $333 million to the Guard and Reserve components. This increase was funded by reductions in our Sustainment, and Restoration and Modernization accounts for which we request $2.9 billion, about 10 percent less than last year. We recognize this reduction will expand a backlog of facility investment requirements that already totals nearly $20 billion. To assure continued focus on taking care of our airmen and their families, the fiscal year 2017 President's budget also requests $274 million for Military Family Housing operations and maintenance, and $61.4 million for Military Family Housing Construction, $56.4 million for Base Realignment and Closure and $842 million for Environmental programs.

MILITARY CONSTRUCTION

The fiscal year 2017 MILCON program consists of three primary tiers. The first is support to the COCOMs; the second is providing facilities for the beddown of new weapons systems by their need dates; and the third is replacing our most critical existing mission degraded infrastructure on a worst-first basis.

COCOM Support

This year's President's budget request includes $293 million for COCOM requirements; $35 million for Central Command (CENTCOM), $97 million for European Command (EUCOM), $29 million for Northern Command (NORTHCOM), and $293 million for Pacific Command (PACOM). The Air Force continues with phase three of the U.S. European Command Joint Intelligence Analysis Center consolidation at Royal Air Force (RAF) Croughton, United Kingdom, which also supports four other COCOMs. Additionally, the Asia-Pacific Theater remains a focus area for the Air Force where we will make a $109 million investment in fiscal year 2017 to ensure our ability to project power into areas which may challenge our access and freedom to operate, and continue efforts to improve resiliency. Guam remains one of the most vital and accessible locations in the western Pacific. For the past 10 years, Joint Region Marianas (JRM)-Andersen AFB, Guam has housed a continuous presence of our Nation's premier air assets, and will continue to serve as the strategic and operational center for military operations in support of a potential spectrum of crises in the Pacific. Additionally, fiscal year 2017 investments in the Pacific Theater include Kadena Air Base, Japan; Royal Australian Air Force Base (RAAF) Darwin, Australia; and the Commonwealth of Northern Marianas Islands (CNMI).

To further support PACOM's strategy, the Air Force is committed to hardening critical structures, mitigating asset vulnerabilities, increasing redundancy, fielding improved airfield damage repair kits and upgrading degraded infrastructure as part of the Asia-Pacific Resiliency program. In 2017, the Air Force plans to construct a Satellite Communications Command, Control, Communications, Computers and Intelligence facility at JRM-Andersen AFB, Guam to sustain Guam's continued functionality. The Air Force also intends to recapitalize the munitions structures in support of the largest munitions storage area in the Air Force. Furthermore, the fiscal year 2017 budget invests in the aircraft parking apron expansion and aircraft maintenance support facility projects at RAAF Darwin supporting the Air Force's participation in bilateral training exercises. The fiscal year 2017 PB investment also includes a land acquisition in CNMI, to support the Air Force's operational capability to execute weather diverts, accomplish training exercises and respond to natural disasters. Our total fiscal year 2017 COCOM support makes up 16 percent of the Air Force's MILCON request.

New Mission Infrastructure

The fiscal year 2017 President's budget request includes $623 million of infrastructure investments to support the Air Force's modernization programs, including the beddown of the F–35A, KC–46A, Combat Rescue Helicopter (CRH) and the Presidential Aircraft Recapitalization. The Air Force's ability to fully operationalize these new aircraft depends not only on acquisition of the aircraft themselves, but also on the construction of the aircraft's accompanying hangars, maintenance facilities, training facilities, airfields and fuel infrastructure.

The fiscal year 2017 PB includes $132.6 million for the beddown of the KC–46A at five locations. This consists of $11.6 million at Altus AFB, Oklahoma, the Formal Training Unit (FTU); $8.6 million at McConnell AFB, Kansas, the first Main Operating Base (MOB 1); $1.5 million at Pease International Tradeport Air National Guard Base (ANGB), New Hampshire, the second Main Operating Base (MOB 2); $17 million at Tinker AFB, Oklahoma, for KC–46A depot maintenance; and $93.9 million at Seymour Johnson AFB, NC, the preferred alternative for the third Main Operating Base (MOB 3).

This request also includes $340.8 million for the beddown of the F–35A at five locations consisting of $10.6 million at Nellis AFB, Nevada; $20 million at Luke AFB, Arizona; $10.1 million at Hill AFB, Utah; $315.6 million at Eielson AFB, Alaska; and $4.5 million at Burlington International Airport, Vermont. Additionally, the fiscal year 2017 investment includes $7.3 million in support of the CRH beddown at Kirtland AFB, New Mexico. As the Air Force continues its efforts to modernize its fleet, we have moved forward to select installations to beddown our newest airframes. In January of this year, we announced the enterprise and criteria for the fourth KC–46A Main Operation Base (MOB 4).

In preparation for the Presidential Aircraft Recapitalization acquisition, the Air Force's 2017 budget request accounts for the planning and design requirements essential to this future beddown and a project to relocate the Joint Air Defense Operations Center Satellite Site at Joint Base Andrews, Maryland.

Existing Mission Infrastructure Recapitalization

This year's President budget request also includes $723 million in MILCON recapitalization projects addressing existing mission infrastructure. Existing mission projects include requirements that revitalize the existing facility plant and projects

that address new initiatives for capabilities already contained in the Air Force inventory. The Air Force's fiscal year 2017 PB supports Nuclear Enterprise priorities and includes three MILCON projects, totaling $41 million. With this budget submission, the Air Force intends to provide a Missile Transfer Facility at F.E. Warren AFB, Wyoming, which recapitalizes the current facility and continues to ensure proper processing of missiles in support of the Missile and Alert Launch Facilities at three sites. The fiscal year 2017 budget also includes a Consolidated Communications Facility recapitalization project at Barksdale AFB, Louisiana. Additionally, a new Missile Maintenance Dispatch Facility at Malmstrom AFB, Montana will be built in support of the UH–1 Helicopter and Tactical Response Force facilities beddown. Together, these projects will consolidate scattered installation functions and provide adequately sized and configured operating platforms for the UH–1 recapitalization. Additionally, the fiscal year 2017 PB request includes three munitions storage projects to accommodate the realignment and relocation of primary Standard Air Munitions Package assets from McConnell Air Force Base, Kansas to Hill Air Force Base, Utah.

The Air Force's fiscal year 2017 PB supports airfield recapitalization requirements to include a project to construct an updated, properly sized Air Traffic Control Tower at McConnell Air Force Base, Kansas and a new aircraft maintenance hangar in support of the Global Hawks at JRM-Andersen AFB, Guam. Additionally, the Air Force's fiscal year 2017 PB supports force protection recapitalization requirements to include a project that constructs a compliant main gate complex at RAF Croughton, United Kingdom and new Combat Arms Training Maintenance facilities at Buckley Air Force Base, Colorado, Yokota Air Base, Japan, and Joint Base-Andrews, Maryland.

In total, our fiscal year 2017 request represents a balanced approach ensuring critical infrastructure requirements to meet mission needs and operational timelines.

FACILITY SUSTAINMENT, RESTORATION AND MODERNIZATION

In fiscal year 2017, the Air Force requests $2.9 billion for Facilities Sustainment, Restoration and Modernization (FSRM), which is approximately 10 percent less than our fiscal year 2016 PB request and funds sustainment to 77 percent of the OSD modeled requirement. The Restoration and Modernization account is reduced by 34 percent in fiscal year 2017 as compared to fiscal year 2016. The Air Force cut this account in order to increase the MILCON program and therefore reduce the greatest risk within the facility infrastructure portfolio this year. Nonetheless, the Air Force's fiscal year 2017 FSRM request attempts to keep "good facilities good" as the AF continues to focus limited resources on "mission critical, worst-first" facilities through application of asset management principles.

HOUSING

During periods of fiscal turmoil, we must never lose sight of our airmen and their families. Airmen are the source of Air Force air power. Regardless of the location, the mission, or the weapon system, our airmen provide the innovation, knowledge, skill, and determination to fly, fight and win. There is no better way for us to demonstrate our commitment to service members and their families than by providing quality housing on our installations. The Air Force has privatized its military family housing (MFH) at each of its stateside installations, including Alaska and Hawaii. The Air Force has 32 projects at 63 bases, with an end-state of 53,240 homes and we are now focused on long-term oversight and accountability of the sustainment, operation and management of this portfolio.

Concurrently, the Air Force continues to manage approximately 18,000 Government-owned family housing units at overseas installations. Our $274 million fiscal year 2017 Family Housing Operations and Maintenance (O&M) sustainment funds request allows us to sustain adequate units and improve inadequate units, and our $61.4 million request for Family Housing Construction funds improves 204 tower units at Camp Foster, Okinawa and 12 units on Kadena Air Base. This request will ensure we support the housing requirements of our airmen and their families as well as the Joint Service members the Air Force supports overseas.

Similarly, our focused investment strategy for dormitories enables the Air Force to achieve the DOD goal of 90 percent adequate dormitory rooms for permanent party unaccompanied airmen, while continuing to support airmen in formal training facilities. The fiscal year 2017 PB MILCON request includes two training dormitories at Fairchild AFB, Washington and Joint Base San Antonio, Texas. With congressional support, we will continue to ensure wise and strategic investment in these quality of life areas to provide modern housing and dormitory communities.

More importantly, your continued support will take care of our most valued asset—our airmen and their families.

AIR FORCE COMMUNITY PARTNERSHIP PROGRAM

In support of the Air Force priority to "make every dollar count", the Air Force has put a concentrated effort to cultivate partnerships between our installations and the local communities. The Air Force Community Partnership program has been heralded by our Wing Commanders and community leaders as an ideal forum for exploring win-win partnerships. To date, there are 53 installations and communities participating in the Air Force Community Partnership program. Since the program's inception in 2013, we have completed more than 140 partnership agreements that have generated over $23 million in Air Force benefits and $24 million in community benefits. Beyond the tangible savings, the program creates an invaluable forum for fostering relationships and promoting innovation. Installations and communities now have the framework and tools needed to finalize many of the over 1,000 potential initiatives identified to date, such as shared medical/EMT training, joint small arms ranges, and shared refuse management services.

Without losing focus on fostering a partnership mentality across the Air Force, we are now turning our attention to cultivate initiatives that show significant promise of large returns-on-investment (ROI) or have Air Force-wide application. In the future, the Air Force Community Partnership program will continue to strengthen its foundation by building upon concepts under development while reallocating resources towards initiatives with large returns on investment.

Of course, we need your help to pursue the initiative, which has, by far, the largest return-on-investment—Base Realignment and Closure.

BASE REALIGNMENT AND CLOSURE (BRAC)

The Air Force has more infrastructure capacity than our missions of today and tomorrow require. Our numbers of aircraft and personnel have drawn down significantly since the Cold War. Since the last round of BRAC in 2005, we have continued to drawdown our forces, but we have not paired these drawdowns with comparable reductions in our infrastructure. Since BRAC 2005, the Air Force has thousands fewer personnel and hundreds fewer aircraft in our planned force structure, yet we have not closed a single installation in the United States. Ultimately, we are paying to retain more installations than we require, and that money could be used to recapitalize and sustain our weapons systems, on readiness training, and on investing in airmen quality of life programs.

Congress has expressed concerns that BRAC may cost too much, is often hard on communities, and may not adequately consider potential future growth of our forces.

Regarding cost, Air Force experience shows that BRAC provides significant savings. BRAC pays for itself. In each prior round of BRAC, including BRAC 2005, the Air Force achieved net savings during the implementation period. Couple that with the plain truth that the Air Force simply cannot afford to maintain our current infrastructure footprint, and our request for BRAC makes fundamental economic sense. The Air Force has a $20 billion facility investment backlog. We estimate (parametrically) that we currently have about 30 percent excess infrastructure capacity when measured against our fiscal year 2019 force structure. Sustaining and maintaining this extra infrastructure further strains our limited funds by forcing us to spread them even thinner to support infrastructure that we simply do not need. Without previous rounds of BRAC, the Air Force infrastructure bill would be about $3 billion higher each year than it is now. BRAC has been effective in reducing our infrastructure cost and we need another round to truly align our infrastructure to our force structure. We acknowledge there will be upfront costs, but those costs are the down payment to significant savings in the future.

Regarding BRAC's impact on communities, we understand that Air Force installations are key components of their communities. These communities house not only our missions but also our families; our kids go to the local schools; our airmen attend the local sporting events; our families volunteer across the spectrum of activities—these communities are our neighbors. With that in mind, the Association of Defense Communities asked our neighbors what they thought about BRAC, and 92 percent of community leaders [1] believe BRAC is better for their community than the status quo of hollowed bases, reduced manning and minimal investment. As BRAC is, by nature, a consolidation effort, some installations will be the recipients of new

[1] From the June 2015 Association of Defense Communities National Summit at which General Session audience members were asked: "What would be worse for defense communities?" and chose from "Status Quo" or "BRAC".

missions and these communities will benefit from the economic boost that increased installation activity will provide. Other installations will close; however, it is only under BRAC that communities whose bases are closing will receive direct economic support through redevelopment guidance and financial assistance. Based on prior rounds of BRAC, communities in which bases closed had lower unemployment rates and higher per capita income growth than national averages.[2] Additionally, the Air Force is committed to partnering with DOD, Congress, and communities to consider alternative approaches to the prolonged BRAC analysis and selection process that puts an economic drag on all communities surrounding military installations. In sum, without a BRAC, the Air Force will continue to spread out our people and force structure, and as this occurs many communities will continue to suffer the economic detriment of hollowed out bases without the economic support that BRAC legislation provides. This lose-lose scenario can only be reversed through BRAC.

Finally, Congress has expressed concerns that a BRAC will enable reductions in infrastructure that do not account for potential future force structure growth. In asking for the authority to permanently reduce our infrastructure footprint, the Air Force has considered both its needs for today and its needs for the future. The Air Force has no intent to close infrastructure that may support any realistically achievable surge or contingency needs of the future. While we estimate 30 percent excess infrastructure capacity, the Air Force would build specific reduction targets on future needs, and seek to reduce only infrastructure that exceeds future scenarios. BRAC would be driven first by a military value assessment grounded in operational needs, and would not compromise future growth in force structure. In comparing infrastructure capacity with force structure requirements going back to the 1990s, the Air Force has never dipped below 20 percent excess infrastructure capacity[3] despite numerous force structure changes and five previous rounds of BRAC. Thus, we believe we have the opportunity to significantly reduce excess capacity while ensuring more than adequate infrastructure to support any envisioned force structure. Further, we are certain that BRAC provides the most effective means for our infrastructure to achieve the right balance of effectiveness, efficiency, and support to AF missions.

CLIMATE CHANGE

The 2010 and 2014 Quadrennial Defense Reviews (QDRs) recognized that climate change will shape DOD's operating environment, roles, and missions, and that we will need to adjust to the impacts of climate change to our facilities, infrastructure and military capabilities. As part of a larger DOD effort, the Air Force recently collected data from over 1,500 sites regarding impacts from past severe weather events. Surveyed sites not only included major installations, but also radar/communications sites, housing annexes, training ranges, missile sites, etc. Sixty percent of all sites reported some impact due to past flooding, extreme temperatures, drought, wildfire, and wind. The single most prevalent factor was drought which accounted for 42 percent of all reported impacts, followed by non-storm surge flooding and wind with 19 percent each. Further, roughly a third of the 78 sites within 2 kilometers of the coast reported having experienced storm surge flooding.

There are several pertinent examples of how climate change is affecting our plans for current and future infrastructure operations. The Air Force recently completed a study on the risks of coastal erosion to remote Alaskan radar sites. Our radar stations are at risk due to rapid, significant coastal erosion because the shore ice that used to protect the coast from waves has melted. We continue to study the rate of erosion, mitigate impacts and incorporate considerations in future planning for these sites.

The DOD climate survey provided qualitative data that helped to frame a more holistic understanding of the impacts of climate on installations and operations. For the majority of reported severe weather events, bases reported emergency preparedness actions and procedures were successful in mitigating impacts on mission and personnel. That being said, mitigation becomes more difficult and cumulative impact to missions more crippling with increasing frequency and/or magnitude of severe weather events. The Air Force continues to integrate climate considerations into individual mission and installation planning efforts to produce informed and resiliency-focused decisions.

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[2] From Government Accountability Office (GAO) studies GAO–05–138 and GAO–13–436.

[3] From DOD reports to Congress on BRAC and capacity in April 1998 and March 2004 in accordance with section 2912 of the Defense Base Closure and Realignment Act of 1990.

ENERGY

The Air Force is the largest single consumer of energy in the Federal Government. Air Force budgetary constraints have strained investments in right-sizing, modernizing, and maintaining power systems. As energy costs increase and budgets decrease, energy places greater pressure on the constrained Air Force budget. From a cost perspective, in fiscal year 2015, the Air Force spent approximately $8.4 billion on fuel and electricity, with more than 86 percent going towards aviation fuel. That $8.4 billion represented approximately 8 percent of the total Air Force budget; only 10 years ago, less than 4 percent of the budget went towards energy expenses. As we refocus our efforts, the Air Force will take a multi-faceted energy investment approach to enhance mission assurance.

MISSION ASSURANCE THROUGH ENERGY ASSURANCE

The Air Force's ability to accomplish its mission—whether executing today's fight or training for future fights—is dependent on fuel and installation electricity. We must ensure reliable, resilient, cost-competitive power for our airmen to fly, fight and win. To do so, the Air Force has revectored its installation energy program from a largely conservation oriented stance to one of energy resilience through strategic agility in installation energy programs and projects. The guiding tenet for this strategic agility is "Mission Assurance Through Energy Assurance." This new paradigm focuses on providing the Air Force with the ability to complete its mission in light of disruptions to electricity and fuel, as well as optimizing its energy productivity through improvements in technology and process.

INSTALLATION ENERGY

Over the last several years, the Air Force has seen installations lose power for significant periods of time as a result of ice storms, hurricanes, fallen trees, and other forms of denial of service. So far, the Air Force has been able to mitigate the most critical mission impacts due to those power losses by exercising alternatives such as moving missions in the case of weather events. There are several critical missions, however, that cannot be moved and where even a microsecond interruption in power puts Air Force mission capabilities at risk. Even though the Air Force has reduced its energy intensity by more than 23 percent since fiscal year 2003, we still rely almost exclusively on expensive, non-networked diesel generators limited to very specific systems to provide the only depth of resiliency beyond that inherent in the electrical grid in our system. While that can be sufficient for short outages, today's grid is increasingly threatened by cyber incursions and physical attacks designed to disrupt power; increasing frequency and severity of natural disasters; and malfunctions from human error, aging equipment, and faulty infrastructure; all with the potential for long-term outages. To that end, we must enhance the energy resilience of Air Force installations through the adoption of innovative technologies and business models.

Going forward, the Air Force will transition to a more comprehensive approach to installation energy challenges, and it will holistically optimize cost and provide resilient, cleaner sources of energy by balancing the objectives of AF energy projects, including energy efficiency, renewable energy, energy resilience, and other energy projects. The core principles below will continue to characterize Air Force installation energy projects, but with an increased focus on meeting multiple objectives within single projects.

—*Resilient:* Every Air Force energy project should be designed through the lens of enhancing energy resilience; the strategic energy agility to maintain critical mission functions even during unexpected disruptions. Air Force missions require agile networks of platforms, communications equipment, satellites, and other technology and equipment. The Air Force will secure critical infrastructure and missions through a layered approach to energy resilience, taking advantage of rapidly evolving energy technologies to meet both home station and expeditionary needs. The Air Force will buttress commercial power with on-site electricity generation (preferably cleaner) paired with smart distribution networks and cyber-secure control systems, enabled to power critical infrastructure during grid disruptions.

—*Cost-competitive:* Air Force installations and commands should continue to "make every dollar count" when acquiring advanced, cleaner energy projects, while also examining trade-offs between lowest price and other priorities such as resilience. The Air Force will continue to pursue energy projects or transactions that will save money, leverage third-party investment, and prioritize resources to projects that also enhance energy resilience and reliability.

—*Cleaner:* Three global trends identified in "America's Air Force: A Call to the Future" (rapidly evolving technologies, decreasing availability of natural resources, and diverse operating environments) work in favor of energy modernization. Renewable and other distributed energy technologies are key components of energy agility and assurance, especially when projects are on site and capable of delivering continuous energy when the grid is disrupted.

RESILIENCE

To help achieve Air Force energy resiliency goals, the Secretary and the Chief of Staff of the Air Force established the Air Force Office of Energy Assurance (AF–OEA) to serve as a central management office dedicated to the development, implementation, and oversight of privately-financed, large-scale renewable and alternative energy projects. This office leverages partnerships with the Army's Office of Energy Initiatives and Navy's Renewable Energy Program Office to develop projects that contribute to strategic energy agility by identifying and awarding third-party financed energy projects that provide 10MW or greater and cleaner (but preferably renewable) power that increases energy resiliency. These projects will provide significant energy alternatives to assure Air Force missions in the event of grid outages for short or long periods. The Air Force is establishing this office with existing personnel resources and will not include any new headquarters personnel; rather, it will co-locate AF–OEA with the Army's Office of Energy Initiatives to share support and processes, and move forward as a team. The AF–OEA will proactively team with the Navy's Renewable Energy Program Office to optimize opportunities that office identifies.

Finally, AF–OEA is charged to take a holistic, enterprise-level approach to its energy assurance programs brought to bear on the Air Force's mission assurance through an energy assurance approach. This includes clean, cost-competitive, reliable and resilient energy through the application of utilities privatization, power purchase agreements, direct investment (e.g., energy conservation investment program), and third-party financed (e.g., ESPCs, etc.) authorities Congress has granted the Air Force. All available tools will be used.

COST COMPETITIVE

Although current and projected energy prices are relatively low, from a mission perspective, price volatility does not change mission vulnerability. With mission assurance as our focus, the Air Force still recognizes the need to reduce the cost of energy to allow our dollars to support readiness and recapitalization requirements. The Air Force directly invests in facility energy projects primarily using FSRM funding based on Air Force priorities. Based on an historical average, the Air Force anticipates approximately $223 million of its FSRM funding going towards projects with energy benefits such as increased resiliency and efficiency through modernized infrastructure.

While the Air Force has made considerable progress to avoid costs through reduced energy consumption, there is more to do. The Air Force is pursuing Energy Savings Performance Contracts (ESPC) and Utility Energy Service Contracts (UESC) to fund energy conservation projects. Since fiscal year 2012, the Air Force has awarded approximately $128 million across eight ESPCs and UESCs. In fiscal year 2016, the Air Force expects to award up to $359 million in such contracts. To take advantage of existing expertise, the Air Force has also partnered with the Defense Logistics Agency (DLA) and the U.S. Army Corps of Engineers (USACE) to expand its ability to identify and execute third-party performance contracts.

CLEAN ENERGY

The Air Force recognizes both clean energy, and its more desirable renewable subcomponent, are key elements to diversifying our energy portfolio to achieve strategic energy agility. By the end of fiscal year 2015, the Air Force had 311 renewable energy projects on 104 sites, either installed, in operation, or under construction, across a wide variety of renewable energy sources, including wind, solar, geothermal, and waste-to-energy projects. Cumulatively, the Air Force has 104.3 megawatts of on-base renewable energy capacity. These projects, which are typically owned and operated by private industry, have increased energy production on Air Force installations by more than 26 percent from fiscal year 2014 to fiscal year 2015. About 8 percent of the Air Force's total electrical energy consumption in fiscal year 2015 came from a mixture of renewable on-base projects and purchased commercial renewable supply. Unfortunately, little of this energy can be directly consumed by our bases in the event of a grid outage. As we evaluate both direct investment and third party investment opportunities, the Air Force will exhibit preference

for renewable solutions where cost effective, followed by clean but not renewable solutions, and ultimately by solutions that provide mission assurance through energy assurance without a clean element.

THE SWEET SPOT

Each of the principles above are spectrums, and the Air Force does not consider them "either-or" choices. The "sweet spot" projects will have elements of all three core principals, but not every project will demonstrate every characteristic. The Air Force will expect each project to demonstrate a clear connection to at least two principles. Projects that only achieve one principle will need strong mission justification. In short, energy projects should move toward the "sweet spot."

OPERATIONAL ENERGY

Similar to the installation energy program, mission assurance is the basis for the Air Force's operational energy program. Through behavioral and technological advancements, the Air Force is optimizing its capabilities in order to maximize combat readiness and reduce the mission risks posed by our fuel supply challenges. With more than 5,000 aircraft in the Air Force fleet, and a demand for over two billion gallons of jet fuel every year, improving how the aircraft and crew use their fuel can generate significant increases in capabilities. To address the risks posed by that demand, the Air Force has a goal to improve its fleet aviation energy efficiency, defined as productivity per gallon, by 10 percent by 2020. Since developing the goal in fiscal year 2011, the Air Force has improved its aviation energy efficiency by almost 6 percent through a combination of materiel solutions and changes to policies and processes.

The Air Force is requesting $682.6 million in operational energy related funding for fiscal year 2017. Included in this is $567.1 million to increase future warfighter capabilities, $4.5 million to reduce the logistical risks to the mission from energy, and $111.0 million to improve current mission effectiveness.

MATERIEL SOLUTIONS

The Air Force faces a challenge when implementing materiel solutions, as many of them require high upfront investments with long-term paybacks. However, those paybacks often provide significant returns in both fuel savings and reduced maintenance requirements. The Air Force is in the midst of a propulsion upgrade program for the KC–135 at a rate of 100 to 120 engines per year for the next 12 years, at a cost of approximately $106 million per year. While this is primarily a service-life extension effort, it provides a 1.5 percent reduction in its fuel consumption rate per engine. Additionally, by improving reliability and durability, these upgrades will provide lifetime fuel and maintenance savings approaching $3 billion.

SCIENCE AND TECHNOLOGY

Part of the Air Force's funding request for fiscal year 2017 is for research, development, test and evaluation (RDT&E) opportunities with operational energy benefits. One of the main operational energy related projects is developing new adaptive engine technology, which provides revolutionary advances in turbine engine performance. By incorporating these advanced technologies, the Air Force will be demonstrating a transformational engine that can operate with the power and performance needed for a combat aircraft, while maintaining the higher fuel efficiency of large aircraft. Based on the results of Air Force lab experimentation, this engine will provide 25 percent greater fuel efficiency, 30 percent greater range, 10 percent greater thrust, and improved thermal management compared to current engines.

MODELING AND SIMULATION

While the Air Force is enhancing its fleet through current and future materiel solutions, it is also looking to improve how it manages fuel usage for future conflicts. As part of the Joint Operational Energy Modeling and Simulation (JOEMS) project, the Air Force is leading a collaborative effort to examine how technology upgrades impact operations in various scenarios through identification of fuel usage requirements and logistical fuel supply challenges. By incorporating energy considerations in wargames and other modeling and simulation efforts, the Air Force can better understand the role fuel and logistics can play in future operations. The way it manages and consumes fuel can be a catalyst towards a successful mission, and the Air Force is driving forward to ensure it maintains an energy advantage against potential adversaries.

PROCESS CHANGES

The Air Force is also actively fostering an energy-aware culture that empowers airmen to take a smart approach to energy to better complete their mission. Simple changes in how a pilot flies and trains can affect aircraft fuel consumption. Through the Energy Analysis Task Force (EATF), the Air Force studied how instructor pilots and simulator instructors at Vance AFB in Oklahoma could incorporate fuel efficiency concepts into pilot training to ensure new pilots understand how to optimize fuel use. As part of a year-long trial, the EATF developed four training techniques to reduce fuel consumption in the T–1A Jayhawk, which were tested in T–1 simulators with a small group of students. The energy efficiency techniques explored for integration into the T–1 syllabus have the potential to save up to 6 percent in fuel requirements on navigation training sortie profiles. One of these techniques, called the Fuel Efficient Descent, involves teaching student pilots to select the optimal point to begin their descent into an airfield. When the students select the correct point to begin their descent, they are able to reduce engine power to idle and descend using minimum fuel. So far, the new technique has proven the potential to reduce fuel usage by 35 percent during the descent phase of flight.

While this effort saves fuel today, it goes much further by instilling an energy aware culture in those new pilots, which proliferates into the Air Force's major weapons systems and will potentially provide exponential savings. This type of savings can be seen in the process changes executed at Altus AFB in Oklahoma, which instituted scheduling and airspace utilization initiatives in 2013 that are providing over $60 million in cost savings on an annual basis.

ALTERNATIVE AVIATION FUEL

The Air Force is also committed to diversifying the types of energy and securing the quantities necessary to perform its missions, both for near-term benefits and long-term energy resiliency. The ability to use alternative fuels in its aircraft provides the Air Force with enhanced capabilities by increasing the types of fuels available for use. The entire Air Force fleet has been certified to use two alternative aviation fuel blends; one of these is generated from traditional sources of energy and the other one is generated from bio-based materials.

ENVIRONMENTAL STEWARDSHIP

While the Air Force strives to prevent or minimize environmental degradation from our training activities and operations, we recognize that sustaining the world's most capable Air, Space, and Cyber Force inevitably results in environmental impact. As a result, we view our responsibility to protect human health and the environment as an extraordinary duty. The Air Force is subject to the same environmental statutes and regulations as any other organization in the country and recognizes both its legal and inherent environmental responsibility. The Air Force fiscal year 2017 PB request assures our programs comply with applicable regulatory requirements but, more significantly, in a manner that ensures the ready installations and resilient natural infrastructure necessary to support the Air Force mission now and in the future.

Environmental Program Funding Details

Within our environmental programs, the Air Force continues to prioritize resources to ensure our defense activities fully comply with legal obligations and our natural infrastructure remains resilient to support our mission and our communities; restore sites impacted by Air Force operations; and continuously improve. The fiscal year 2017 PB seeks a total of $842 million for environmental programs. This is $20 million less than last year due to sustained progress in cleaning up contaminated sites and efficiencies gained through centralized program management. By centrally managing our environmental programs we can continue to fund full compliance with all applicable laws, while applying every precious dollar to our highest priorities first. Further, our environmental programs are designed to provide environmental stewardship to ensure the continued availability of the natural infrastructure; the air, land and water necessary to provide ready installations and ensure military readiness.

Environmental Quality

The Air Force's fiscal year 2017 PB request seeks $422.6 million in Environmental Quality funding for environmental compliance, environmental conservation, and pollution prevention. With this request, the Air Force ensures a resilient natural infrastructure and funds compliance with environmental laws in order to remain a good steward of the environment. We have instituted a standardized and centralized re-

quirements development process that prioritizes our environmental quality program in a manner that minimizes risk to airmen and surrounding communities, the mission and the natural infrastructure. This balanced approach ensures the Air Force has ready installations with the continued availability of the natural infrastructure it needs at its installations and ranges to train and operate today and into the future.

The environmental compliance program focuses on regulatory compliance for our air, water and land assets. Examples of compliance efforts include more detailed air quality assessments when analyzing environmental impacts from Air Force activities; protecting our groundwater by improving management of our underground and aboveground storage tanks; and properly disposing of wastes to avert contaminating our natural infrastructure.

Efforts in pollution prevention include recycling used oil, fluorescent lights and spent solvents, as well as sustaining our hazardous materials pharmacies to manage our hazardous materials so they don't turn into waste. We continue to make investments in minimizing waste and risk to airmen through demonstrating and validating new technology such as the robotic laser de-painting process on aircraft.

The Air Force remains committed to a robust environmental conservation program. Prior appropriations allowed the Air Force to invest in conservation activities on our training ranges, providing direct support to mission readiness. The conservation program in fiscal year 2017 builds on past efforts to continue habitat and species management for 96 threatened and endangered species on 45 Air Force installations. This year's budget request also provides for continued cooperation and collaboration with other agencies, like the U.S. Fish and Wildlife Service, to provide effective natural resources management and safeguard military lands from wildfire hazards through coordinated planning and incident response, and the application of prescribed burn techniques. The fiscal year 2017 budget will further the Air Force's implementation of tribal relations policy to ensure that the unique trust relationship the U.S. Government shares with tribes continues, and to provide opportunities to communicate aspects of the Air Force's mission that may affect tribes.

As trustee for more than 9 million acres of land including forests, prairies, deserts, wetlands, and costal habitats, the Air Force is very aware of the important role natural resources plays in maintaining our mission capability. Sustained military readiness requires continued access to this natural infrastructure for the purposes of realistic training activities. The Air Force utilizes proactive ecosystem management principles and conservation partnerships with other Federal and State agencies to minimize or eliminate impacts on the training mission. We are challenged by the fact that in many instances, our installations have become the last bastion of habitat for certain species due to the increased development outside the installation boundary. The fiscal year 2017 PB request includes $53.4 million to implement the Air Force's conservation strategy, which will ensure that all aspects of natural resources management are successfully integrated into the Air Force's mission.

The Air Force remains committed to good environmental stewardship, ensuring compliance with legal requirements, mitigating mission impacts, reducing risk to our natural infrastructure, and honing our environmental management practices to ensure the sustainable management of the resources we need to fly, fight, and win now and into the future.

Environmental Restoration

The Air Force fiscal year 2017 PB request seeks $419 million in Environmental Restoration funding for cleanup of current installations and those closed during previous BRAC rounds. Our focus has been on completing investigations and getting remedial actions in place, to reduce risk to human health and the environment in a prioritized manner. Ultimately, the Air Force seeks to make real property available for mission use at our active installations, and to facilitate community property transfers and reuse at our closed installations.

The Air Force has made progress over time in managing this complex program area, with more than 13,500 restoration sites at our active and closed installations (over 8,200 active and almost 5,300 BRAC). The Air Force BRAC restoration program is on-track to achieve, at least, a "response complete status" at 90 percent of its Installation Restoration Program (IRP) sites at closed installations by the end of fiscal year 2018. Our active installation restoration sites are currently projected to achieve the same 90 percent response complete level by fiscal year 2020.

A new topic of focus is Emerging Contaminants (EC). ECs pose significant risk management challenges to the Air Force environmental program. Regulatory requests for environmental sampling and implementation of EC response actions are on the rise.Characterizing the extent of Air Force environmental releases of an

emerging contaminant, assessing the potential risk and impact to human health and the environment, and initiating response actions and implementing appropriate mitigation measures, drive unforeseen, chemical- and site-specific environmental liabilities and program costs.

The Air Force response to releases of ECs from its facilities is a deliberate, science-based and data-driven process that is focused on protection of human health and the environment, conducted in accordance with the Defense Environmental Restoration Program, and consistent with the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA).

The Air Force continues to work with regulators, city and State officials and other stakeholders to develop the best solution to an emerging problem. For example, for confirmed perfluorinated compounds (PFC) releases, the Air Force is determining the extent of contamination and taking steps to mitigate any validated human exposures with interim actions until cleanup standards and effective remedial technologies are available. When groundwater sampling results indicate PFC levels exceed the EPA's provisional health advisory for drinking water, the Air Force reduces PFC levels with filtration technologies or provides an alternate drinking water source. When PFCs are detectable, but below the provisional health advisory level, the Air Force may conduct well monitoring to track PFC level changes and determine if further action is needed.

While we cannot compromise on the protection of the public, our airmen and civilian workforce and their families, neither can we endlessly absorb the operational and financial risks of attempting to work with a myriad of unregulated contaminants without some level of certainty that the cost of controlling exposure will have a commensurate public health and operational benefit.

CONCLUSION

The Air Force made hard strategic choices during formulation of this budget request. The Air Force attempted to strike the delicate balance between a ready force for today with a modern force for tomorrow while also recovering from the impacts of sequestration and adjusting to budget reductions. Our fiscal year 2017 PB request increases funding in MILCON to support COCOM and new weapon system requirements, reduces Restoration and Modernization (R&M) and continues to address the current mission backlog of deferred infrastructure recapitalization from the fiscal year 2013 PB strategic pause. Sequestration will halt this recovery. We also must continue the dialogue on right-sizing our installations footprint for a smaller, more capable force that sets the proper course for enabling the Defense Strategy while addressing our most pressing national security issue—our fiscal environment.

In spite of fiscal challenges, we remain committed to our servicemembers and their families. Privatized housing at our stateside installations and continued investment in Government housing at overseas locations provide our families with modern homes that improve their quality of life now and into the future. We also maintain our responsibility to provide dormitory campuses that support the needs of our unaccompanied servicemembers.

Finally, we continue to carefully scrutinize every dollar we spend. Our commitment to continued efficiencies, a properly sized force structure, and right-sized installations will enable us to ensure maximum returns on the Nation's investment in her airmen, who provide our trademark, highly valued air power capabilities for the Joint team.

Senator KIRK. Let me start with the questioning. I will recognize myself.

Missile defense is one of my greatest priorities as chair of this subcommittee. I would say that I am favorably looking at the expeditionary deployment of Terminal High Altitude Area Defense (THAAD) to Guam as a permanent funding item that we would look at.

I would say to Mr. Potochney, could you tell me more about the $155 million that you guys are planning for the long-range discrimination radar in Clear, Alaska.

Mr. POTOCHNEY. Thank you, sir.

It is in our budget. It is important. We are strongly behind it. We hope you all are. We want the money appropriated this year,

so that we can execute it holistically. I think it is a key element of our approach to missile defense.

Senator KIRK. Mr. Tester.

Senator TESTER. I will yield to Senator Udall.

Senator UDALL. Okay, Thank you, Jon. I appreciate your courtesy.

Thank you both, Chairman Kirk and Ranking Member Tester.

As we all know, the military's ability to meet future global challenges is directly tied to its facilities. That is what it uses to train, to test, to evaluate, and to carry out its mission. So when I look at my home State of New Mexico, I see an array of military installations that provide unique capabilities to the Department of Defense and our mission on the 21st century battlefield.

At Kirtland, we have the Air Force research lab and the nuclear weapons center; at Cannon, the 27th Special Operations group; Holloman has the high-speed test track; and the White Sands Missile Range, otherwise known as WSMR, has 3,200 square miles of unique and pristine testing and evaluation territory that is used across DoD and other agencies.

WSMR is capable of testing next-generation technologies. These will emerge from what DoD is calling the third offset, the focus on technological innovation. Combined, all of New Mexico's bases help build and sustain a 21st century military.

Ms. Hammack, I will direct this question to you. What concerns me is that years of reduced MILCON budgets and deferred maintenance have resulted in facilities and infrastructure that may not be adequate or may not be advanced enough to test and evaluate new technologies. For example, the White Sands Missile Range sustainment, restoration, and modernization budget is funded at only 69 percent. But WSMR has repairs and maintenance backlogs of over $220 million.

Do you agree that the White Sands Missile Range offers unmatched testing and evaluation capabilities that will help develop the next generation weapons systems of third offsets such as directed energy?

WSMR/SUSTAINMENT FUNDING

Ms. HAMMACK. The answer is yes. WSMR offers unmatched testing capabilities, which is used by all services. You are absolutely right. Sustainment funding is lagging. That is the effect to sequestration.

So not only does WSMR have a backlog, but across the Department of Defense, across the Army, in particular, we have a backlog of sustainment that is well over $7 billion today.

So it is one of the significant risks that we are taking in our installation budgets. We are doing our best to ensure, though, that we do not fail the mission. So the money that we have is focused on critical mission requirements and life, health, safety.

Senator UDALL. Could you discuss the Army's plan to address WSMR's maintenance backlog and the budget shortfalls that face us?

Ms. HAMMACK. Unfortunately, right now, we have no plan to handle the maintenance backlog, because we don't have money to

handle the maintenance backlog. That is why we are addressing the worst first.

But the challenge is, as we continue to be unfunded due to budgeting constraints, the backlog will increase. Unfortunately, that means that facilities will fail faster.

Right now, in the Army, 20 percent of our infrastructure that is over 52,000 buildings are in poor or failing condition due to the underfunding in our installation accounts.

Senator UDALL. Mr. Potochney, as you know, a QF–4 unmanned aerial vehicle crashed at White Sands National Monument over 2 years ago. That was in February 2014. But a 4-mile stretch of the monument remains closed today due to serious concerns about contamination in the soil, including access to two popular family-friendly trails.

There have been some frustrating bureaucratic issues preventing cleanup related to interagency funding, but we are not aware of any specific legal obstacle to DoD funding this cleanup.

Will the DoD pay for the cleanup? And can you commit to a timeframe to get it done?

Mr. POTOCHNEY. Sir, thank you for that question.

I am frustrated as well, but we are on a path right now to reconcile the bureaucratic delay that we have had.

The delay resulted from the fact that it was a Navy mission, an Air Force plane, on a facility handled by the Army, and the Army had the agreement with the Park Service for cleanup. So we had to work through that.

I'm not happy at all with the fact that it has taken us this long. I can assure you we are watching it very carefully now, and I cannot commit to a timeline to clean it up, but I do not think it will be too long, and it will be done expeditiously.

The reason why I say I can't commit to a timeline is I don't know how long it will take us to get the last contract in place and how long that contractor will take. But we can take that for the record, as soon as we have that plan in place.

[The information follows:]

INFORMATION MEMORANDUM

Subject: Timeline for Army Cleanup at White Sands Missile Range (WSMR)

Cleanup: Contract award June 2016. Expected completion mid-January 2017, with anticipated regulatory approval by July 2017.

—WSMR Commanding General and White Sands National Monument (WSNM) Superintendent agree that the existing 2-year old site assessment requires a refresh and re-analysis of the crash site.
  —The crash site will be re-assessed to determine extent of contamination
  —Once the new assessment is completed, personnel will excavate and properly dispose of the contaminated soil from the areas showing the highest concentration of jet fuel
  —Personnel will analyze soil samples to verify cleanup levels
  —The Army plans to complete the cleanup of the White Sands Missile Range (WSMR) site by mid-January 2017, with anticipated regulatory approval by July 2017
  —Completion of cleanup could require additional time if the contamination proves to be more extensive or has potentially spread

—Major Milestones are as follows:
  —Contract award—June 2016
  —Work Plan and Site Assessment complete—mid-October 2016
  —Cleanup Action complete—mid-January 2017

—Regulatory review & approval—complete July 2017

—WSMR has the estimated $500,000 funds on hand to contract for remediation and will follow the existing Memorandum of Understanding (MOU) to be subsequently reimbursed by the Navy.

—U.S. Army Corps of Engineers (Tulsa) will award the remediation contract and use a qualified contractor

Senator UDALL. Yes. That's good to hear, and I think it's important we move forward, so we make sure that we have a good, long-term relationship between the Air Force and the White Sand's National Monument, which worked very closely together to achieve, as you know, a lot of these national security objectives.

Mr. POTOCHNEY. Yes, sir. And if I could just add one thing? I'm using it as an illustrative test case, if you will, of how we can do a better job at an interagency decisionmaking, and we will do that.

Senator UDALL. Thank you.

Mr. POTOCHNEY. Thank you.

Senator KIRK. Senator Collins.

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

Secretary Iselin, first, let me tell you that I'm very pleased to see that the President's budget request includes funding for three important projects at the Portsmouth Naval Shipyard in Kittery, Maine.

This shipyard is considered the gold standard. It's the most productive of our four public shipyards. I can say that not only because it's true but there are no other members here representing the other three who could contradict that statement. But it is, indeed, the case, and we're very proud of that.

I particularly am pleased to see that funding of $27 million has been requested to replace the medical and dental clinic. That facility is over 100 years old, and it does not meet standards for safety, for accessibility. And it does not allow for a smooth and efficient delivery of services, as you might imagine, given the age of the building.

So I just want to go on record in support of those three projects, and thank you for including them and recognizing their importance.

I do want to bring up a longer range issue that is of concern to me. We all know that fleet readiness is a key component of our Navy's capability to project power and deploy assets. Our Nation's four public shipyards ensure this readiness as they restore, repair, and modernize ships and submarines at dry docks.

According to NAVSEA and the Navy Shore Mission Integration Group, however, naval shipyard dry dock capacity is inadequate to service future fleet maintenance needs. And my concern is, without this capacity, the readiness of our ships and submarines is placed at risk, and we will be left vulnerable, particularly as we look at what China and Russia are doing.

So to respond to these threats, we must invest in dry docks, a critical component of fleet maintenance.

The necessary levels of investment in those dry docks is currently estimated at $2 billion divided among the four public naval shipyards.

Can you give us some concept of how the Navy plans to fund these future requirements and ensure that dry docks are available

and properly maintained, and able to keep our fleet operationally ready and strong?

Mr. ISELIN. Yes, ma'am.

First, thanks for your compliment on supporting the funding for those facilities at Portsmouth. I was stationed there over 30 years ago and have fondness in my heart. I had a broken thumb set at that medical facility, and it was old then and it's older now. So we're happy to be able to make those investments.

As to your broader question about dry docks and really shipyard facilities writ large, we recognize those are critical assets.

There's a finite number of those around the Navy, and we pay close attention in our fiscal year 2017 request. Although it's not overtly visible to you, we have over $70 million targeted for repair projects, six repair projects at the dry docks, some at each of those four public shipyards.

To the bigger question about how we are going to get after the $2 billion backlog, know that we prioritize shipyards and their maintenance.

During the last couple of years, particularly during the days when we were at furlough, the Navy leaders recognized very directly the importance of ship repair capability. We had weight handlers who operated cranes at a shipyard unable to come to work because of a furlough, and we ended up with four star senior leaders directly managing people's days on and days off to make sure that we met the ship repair capability, because that has direct implications on operational readiness.

So we know where our challenges are. As I mentioned, in my opening remarks, we have a very good system of understanding what our critical facilities are. Dry docks clearly are at the top of the list, and we know the condition of them. And the challenge will be to prioritize those facilities along with everything else as we spend the dollars that we have.

I mentioned senior leader's awareness. I've been involved in this business for a long time, and it's an unprecedented level of attention by the Secretary of the Navy, the Chief of Naval Operations (CNO), and the Commandant on the challenges that we're describing here today. So I feel comfortable that the senior leaders are paying close attention on where to make the best investments that we can.

Senator COLLINS. Thank you very much for that thorough response, and please know that you are welcome back to Kittery, to the shipyard, at any time.

Mr. ISELIN. Yes, I was up there last year, and I was really pleased to see how far it's come over the last couple of decades, and the pride that the workforce has in what they do.

Senator COLLINS. That pride is really evident, and I'm very proud of the workers there. Thank you so much.

Senator KIRK. Senator Murphy.

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

Welcome, to all of our witnesses.

Mr. Iselin, I'm going to stay with you. I have the same pride that Senator Collins does in representing the Navy's first submarine base in New London, Connecticut, and I can say the finest base, so long as Senator Schatz is not here.

And Senator Wicker and I got the real honor about 2 weekends ago to actually spend 24 hours on board the USS *Hartford* as it conducted operations in and around the Arctic Circle. And of course, as always, I was incredibly impressed with their skill and professionalism.

But as you are aware, we have committed through the Appropriations Committee process along with the Navy to continuing the two *Virginia*-class submarines, build a year while simultaneously integrating the new *Virginia* payload module into the Block V submarines starting in 2019. And as you also know, these new *Virginia*-class submarines are going to be a lot bigger than the existing *Virginia*-classes and the Los Angeles class submarines.

And so I wanted to ask you about how our military construction budget is going to keep pace with this increase in the number and the size of *Virginia*-class submarines.

Specifically, in New London, Pier 32 needs to be upgraded in order to meet this new requirement starting in 2019. And I'm hoping that you can maybe speak even more generally to the necessary upgrades that are being planned and the needed military construction projects that are in the budget over the next few years to make sure that we have the capacity to deal with this increase in both volume of production but also size of the submarines.

Mr. ISELIN. Yes, sir. Thanks for your question.

And I was fortunate to make a visit up to Sub Base New London last year as well and got a great tour from the installation commander and the staff there who are responsible to look after those very situations.

And I agree with you. We have challenges with the condition of that pier, and that will factor into our future investment plans. Certainly, a pier to support nuclear submarines is high-priority item.

And as it relates to the *Virginia* payload module and the changes in the size and the nature of submarines as a result, that will factor in. The installation team has a long-range plan to make adjustments to the infrastructure to accept that new platform, and that will factor into future planning initiatives.

Senator MURPHY. We look forward to working with you to make sure that that plan stays on track.

The second question for you as well, I certainly understand that you're going to support the broader request from the Department for a BRAC. But I wanted to ask you as to the Navy's very specific disposition. The immediate past CNO Admiral Greenert said in earlier testimony very clearly that the Navy didn't believe that it had a need for base closures or for a BRAC process.

He said, "I'm very satisfied with our lay down of bases. People ask me do you see a great need for BRAC, I say, no, I don't."

And so I understand you'd be supporting the broader request, but has the Navy's disposition changed in terms of its need for a base closure process?

Mr. ISELIN. Thanks for that question and you assume correctly. We do support the Department's request for BRAC. I would say, on a high level, we have much less excess infrastructure capacity than the Army or the Air Force.

We played very aggressively in prior rounds of BRAC to try to get to the right size. We've had the benefit, unlike the other services, of having less fluctuation in our force structure over time, including the projected force structure.

And so we look forward to completing the required capacity analysis, and if a BRAC is authorized, we'll, of course, participate in that process. But I think our challenge is less severe than the Army or the Air Force.

Senator MURPHY. Okay.

Thank you very much, Mr. Chairman.

Senator KIRK. Senator Boozman.

Senator BOOZMAN. Thank you, Mr. Chairman.

Ms. Hammack, tell us about the excess infrastructure in the Army.

Ms. HAMMACK. Thank you for that question.

Currently, the Army has approximately 18 percent excess infrastructure. As force structure continues to decline, we will have 21 percent excess infrastructure when we reach a total force of 980,000. That amounts to over 170 million square feet of unutilized or underutilized facilities.

As we've reduced our force, quite often, we see buildings that are partially occupied. One of the things a BRAC offers us is the ability to consolidate into our best facilities and consolidate missions, and that's why we are asking for BRAC authority.

The previous rounds have consolidated about 5 percent of our infrastructure, and we anticipate that this next round of BRAC would do the same: Consolidate about 5 percent of our existing 21-percent excess, so that we would retain some capacity for surge or other unanticipated requirements.

Senator BOOZMAN. For the panel, if Congress were to grant you the ability to go forward with BRAC, can you tell us what you learned from the last BRAC that we did, some of the things that we should have done better?

Mr. POTOCHNEY. I'll start, if I could.

Senator BOOZMAN. Yes, sir, if you would.

Mr. POTOCHNEY. Congress was rightly concerned about the cost growth from the last round. We had anticipated around $22 billion in cost, and we came in at $35 billion. Some of that was attributable to fact-of-life things. We had a Katrina effect that put our construction materials through the roof. Environmental cleanup is an issue that we have to handle carefully in BRAC, those kinds of things.

But, we, frankly, used the last BRAC round as a recapitalization engine and as a transformation tool, so that we weren't just skinning down excess capacity in place. We were actually looking more broadly. And that's expensive, but it does position us for the future.

What we're saying to you all now is that we're looking at the next round being an excess capacity round to reduce our costs. So that is, if you will, to use your words, a lesson that we've learned.

I would argue, though, that the transformation that was accomplished in the last round was absolutely worthwhile, at least in my judgment and others as well. But as far as a tool to reduce our infrastructure and save money directly, excess capacity is the way to go, and that's what we're looking at now.

Senator BOOZMAN. Ms. Hammack.

Ms. HAMMACK. Let me comment on that.

One of the things that the Army learned is that the Reserve component has an opportunity to participate in BRAC, which they did for the first time in 2005: They closed 387 facilities, consolidating into 125 new readiness centers, which were shared by Guard, Reserve, and, quite often, other Federal agencies like the Fish and Wildlife Service or Department of the Interior Bureau of Land Management.

So the National Guard found that it increased their capabilities and reduced their costs, and, just like the Active Duty and the industrial base, found that there are significant opportunities for efficiencies to save money and prepare us for the future.

Senator BOOZMAN. Very good.

AIR FORCE—2005 BRAC ROUND

Ms. BALLENTINE. I would like to add that for the Air Force in the 2005 BRAC round, it really was a good money-saving exercise, as well as a good transformational exercise. The 2005 round cost the Air Force about $3.7 billion, and we're saving $1 billion a year. That's a pretty good return from the business perspective.

EUROPEAN INFRASTRUCTURE CONSOLIDATION

I would also encourage all of us to look at our recent European infrastructure consolidation as a strong process. We would seek to replicate many of the elements of that process in the next round.

It was very much focused on savings for the Air Force. We're doing nine actions in Europe, and we'll save considerable money with zero loss of operational capability. It really was designed to find ways to be as or more operationally capable from lower cost, fewer installations.

So I would encourage us to look at both, the most recent as well as prior, to get the best lessons learned.

Thank you for the question, sir.

Senator BOOZMAN. Thank you.

Mr. ISELIN. Sir, I don't have anything additional to add. I think they've covered it.

Senator BOOZMAN. Good. Well, that worked out perfectly or the chairman would yell at me, because my time is up. So thank you all very much.

Thank you, Mr. Chairman.

Senator KIRK. Senator Murkowski.

Senator MURKOWSKI. Thank you, Chairman. I appreciate you letting me jump in here.

I would like to start my questions and direct them to you, Assistant Secretary Ballentine.

As you know, we had a pretty good start of the week in Alaska, particularly in Fairbanks, with the announcement of the record of decision (ROD) assigning the two squadrons of F–35 aircraft to Eielson Air Force Base. With a signature of that ROD, we are really very excited for a host of different reasons. This is the first F–35A beddown in the crucial Pacific area of responsibility (AOR).

The administration has requested $295.6 million in fiscal year 2017 to construct seven different projects there at Eielson.

Can you please speak to the importance of this week's decision and explain why it is essential that this subcommittee fully appropriate the administration's request in the 2017 bill and how any possible delay in appropriations could adversely affect the beddown of these two squadrons there at Eielson?

F–35A BEDDOWN—2017 MILCON PROGRAM

Ms. BALLENTINE. Thank you, Senator.

This is a very short, straightforward answer. It's absolutely critical that the full fiscal year 2017 MILCON program that we submitted is funded this year.

With the current timing of the beddown of the first aircraft for both Squadron 1 and Squadron 2, if we do not fully fund this MILCON program, we will be late to need.

And in an environment like Alaska with very harsh winter conditions, it's very difficult for us to create mitigations if we don't have the proper facilities.

In fact, as you also know, we announced a swap of timing for the first squadron with Burlington, Vermont, which in many ways helps to solve some problems that we had previously where we would have been late to need.

So it's absolutely critical with this current timing that we get all of this program funded for both squadrons.

Senator MURKOWSKI. And also, we had discussed the reality that we have a limited construction season in Alaska. You just can't be doing all this outside work 365 days out of the year. So the timing on this is critical.

Ms. BALLENTINE. Yes, ma'am.

Senator MURKOWSKI. Thank you. I appreciate that and would certainly encourage the subcommittee to take very seriously the Assistant Secretary's words here.

Finally, to Assistant Secretary Hammack, this relates to the $47 million for a hangar to house the Gray Eagle unmanned aerial vehicles at Fort Wainwright. Anything you would like to say in support of this request? And, again, in terms of the timing, a very important asset there in the interior as well.

Ms. HAMMACK. Absolutely, and thank you for that question.

I echo Secretary Ballentine. It's critical that we get the money. The vehicles, some are already there in adequate facilities. We need the money so that we can progress within the planned timeframe so that we have the ability to both work on the equipment, maintain, repair, and do the appropriate training that Alaska affords to our soldiers.

Senator MURKOWSKI. Thank you. I appreciate that.

And I understand, Mr. Chairman, that you had already directed a question regarding the Long-Range Discrimination Radar, the significance of that, why it's essential that we provide for the administration's request on that. So I appreciate that, and I also appreciate your commitment to that at Clear.

My final comment would be not directed to any of you necessarily at the table, but I know that General Halverson is with us today, and I know that you have been invited to join us up in Fairbanks perhaps for the military appreciation event coming soon, and I

know that that is something that is under consideration. So I saw you in the audience there and just take the time to do that.

Thank you all for your commitment to ensuring that as we advance these priorities around the Nation, that we do so in a timely and efficient manner.

Thank you, Mr. Chairman.

Senator KIRK. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

High-quality installations like the Wisconsin Air National Guard Truax Field, which is home to the 115th Fighter Wing, rely on adequate capital investments to ensure readiness and support mission success.

The 115th is under consideration to be one of the new National Guard homes of the F–35 with aircraft fielding in 2022. I expect it to be a very strong competitor for a number of strategic, geographic, and economic reasons.

So I'm pleased that this year's budget includes a fiscal year 2019 project at Truax to improve the condition of the facilities used by the 115th medical group. It's a subunit, obviously, of the 115th. This project is the number one priority of the Wisconsin National Guard and will support the training of medical professionals assigned to that unit, the medical readiness evaluation of military members assigned, and a domestic operations capability.

Secretary Ballentine, projects in the Future Year Defense Program (FYDP) sometimes are moved forward and sometimes are pushed back, as the Department builds it budget request.

Considering that by the time this fiscal year 2019 project breaks ground, there will not have been an Air Force MILCON project in Wisconsin for a whole decade, I strongly believe that this project must not be delayed.

Can I have your commitment on that?

Ms. BALLENTINE. Thank you, ma'am.

We do our best to prioritize our mission-critical, worst-first facilities for our existing facilities. Our existing facilities MILCON budgets are highly, highly strained. Of the 500 top priorities submitted by our major command commanders this year, we only were able to fund 30.

So it's a very difficult budget environment for those existing facilities, and I think we've heard that a lot today.

So we certainly do hope that everything that's in the current program will stay in the program, and we will continue to prioritize mission critical worst-first.

I also thought I would just touch on the timing for the Ops 5, 6, and 7 F–35 beddown strategic basing process, which you mentioned. We will be announcing later this month the enterprise definition as well as the criteria, and then we'll go into the scoring period of time.

MILCON BACKLOG

This summer, we hope to approve the candidates and then begin site surveys and hope to be able to announce a preferred and reasonable alternative this fall.

Senator BALDWIN. Thank you.

Secretary Hammack, your testimony notes that the fiscal year 2017 request for the Army National Guard is a small step toward addressing the Guard's facility challenges, and I appreciate your candid assessment of the request and share your concerns with the critical facility shortfalls in the Guard's readiness center portfolio.

The Wisconsin Army National Guard has a 40-percent facility shortfall that directly and significantly affects readiness, recruiting, and equipment management.

My question to you is how can we take bigger steps toward fixing the problem, particularly in this tight budget environment? And specifically, how can the Army support the funding levels called for by the readiness center transformation master plan?

Ms. HAMMACK. I would love to say that there is a solution but the best solution is to lift sequestration. With the budget constraints we're facing, we're having to balance readiness and the missions that are asked of the Army against installations. When we look at manning the Army, training the Army, and equipping the Army, there is very little left for supporting installations and supporting readiness centers.

So we do our best with the limited funding we have, but we have a tremendous backlog in military construction requests, just like the Air Force. We have a tremendous backlog in maintenance requirements, restoration, and modernization requirements. It amounts into the tens of billions of dollars currently, and is only going to grow with time.

So we are taking significant risk in installations and creating a bill for the future by the underfunding that we are forced to live with in this restricted budget environment.

Senator BALDWIN. I know my time is about to run out. Let me just note that as a total force training center, Wisconsin's Fort McCoy plays a crucial role in the training and mobilization of our Armed Forces, ensuring that service members are fully prepared to respond to any contingency. And as such, it's critical that the Army continues to invest in Fort McCoy, maintaining the installation's ability to support the readiness and quality of life of our soldiers and their families.

I'm pleased that the budget does include three projects for Wisconsin's Fort McCoy, including a fiscal year 2017 project to construct a new dining facility to support mobilizing and training soldiers. I will ask you to submit any extra comments for the record as I run out of time.

FORT MCCOY

But, Secretary Hammack, if you can expound in the future about how this budget reflects a strong recognition by the Army that Fort McCoy is essential, not only to the Reserves, but to the total force.

And I thank the chairman.

Ms. HAMMACK. Just a brief reply on that, Senator Baldwin. Fort McCoy is a strategic training asset for the total force. When I was last there, we had Active Duty from Fort Drum training with Guard and Reserve together, training in a realistic environment, and training the way we fight, and that is a great thing. The three projects that were included in our fiscal year 2017 budget request, together with the 17 projects (totaling $223 million) provided over

the last 10 years, are a clear testament to the Army's recognition of Fort McCoy as an essential training platform for the total force.

Senator KIRK. Senator Cassidy.

Senator CASSIDY. Thank you, Mr. Chair.

Assistant Secretary Ballentine, we spoke yesterday. Thank you for coming by. Reflecting on our conversation, you mentioned the need to buy back some force, that the force reductions have been such that now you all need to bring folks back in. Knowing that you're in a rock and a hard place, nonetheless, I'll emphasize the quality-of-life issues that you said in this budget are somewhat deemphasized. If you're going to buy back folks in, it just seems as if they would want to have daycare or such like that, if they're going to rejoin, knowing that you know that, but just to make that point.

Ms. Hammack, knowing, again, that you all are having to prioritize that which is important, and as you might guess, being from Louisiana, I'm very sensitive to the Fort Polk issue, that combat training center. It's fair to say that as you all prioritize, you'll recognize the importance of combat training centers and the need to modernize the joint readiness training centers such as at Fort Polk?

Ms. HAMMACK. Yes, sir, and we do prioritize. Our highest value goes to training land, airspace, and testing ranges, and Fort Polk is a great training environment. But we do have a backlog in construction, and so that's one of the challenges finding enough money to suit all of our requirements.

We are going to be investing there, but it is out in the future years.

Senator CASSIDY. Combat readiness though is almost by definition—it seems to be the number one priority of the Army, to be ready for combat. So that's why I just advocate, not just as a fellow from Louisiana, but as someone who wants to see our troops ready, less likely to be harmed, more likely to affect their mission, to have that at the highest priority.

You also, in your testimony, speak at length regarding the Army's green energy initiative. And you suggest but don't outright state that the investment has paid for itself. Has it? Because it seems as if it's one thing to say that the cost of electricity from a renewable is cheaper than that which you can buy off the grid, but it's another to say that once you factor in the cost of the installation of the infrastructure and the maintenance, that it is still cost effective. So, thoughts?

RENEWABLE ENERGY

Ms. HAMMACK. Absolutely, Senator.

That is why we're not investing Army money in it. The private sector is designing, building, owning, operating, and then delivering us the energy at a lower cost than would otherwise be available.

Senator CASSIDY. What I find interesting though is that you're accomplishing that which others have not, unless they are using the other Federal subsidies that go with green energy. Am I to presume that this energy being received is taking advantage of Fed-

eral tax credits? Because otherwise, green energy typically is not cheaper all in than is conventional, if you will, electricity.

Ms. HAMMACK. Many of them are taking advantage of Federal tax credits, but we have seen the cost of renewable energy decrease whether it's wind, solar, or biomass, it has decreased in all areas. That's why it's a good business decision to have the private sector invest money, because they have to be able to make money out of it, yet deliver us energy at or lower than current energy costs.

Senator CASSIDY. I see that. But at all-in cost to the Federal taxpayer. We also have to consider the cost of the production tax credits or whatever. So granted, it offloads off you, but it's still on the Federal budget.

I just say that not to accuse or to challenge, but just to understand. In a sense, this is a stackable payment.

Okay. I get that.

I yield back. Thank you.

Senator KIRK. Senator Schatz.

Senator SCHATZ. Thank you, Mr. Chairman.

With the exception of our longstanding commitments to the Republic of Korea and Japan, we've largely had a "places, not bases" defense posture in the Asia Pacific. But our footprint is changing, and we have marines in Darwin for half of the year as part of a broader realignment in the region. We also have a new, enhanced defense cooperation agreement with the Philippines where we look to bring rotational forces.

And while this doesn't mean new bases, it does mean new infrastructure to store equipment and support training.

So my question for Secretaries Hammack, Iselin, and Ballentine is, how do you see the overseas MILCON evolving in light of increasing requirements and increasing partnerships in the Asia Pacific region, in addition to what's happening in Korea and Japan?

COST SHARING

And we'll start with Secretary Hammack.

Ms. HAMMACK. Thank you, Senator Schatz, for that question.

One of the things we are evaluating is working very closely with our allies and partners over there to leverage their resources and their capabilities and their bases for storage, so that we can reduce the cost of partnership and joint training exercises. A lot of that is under development right now.

Senator SCHATZ. Are you talking about actual cost-sharing or are you talking about sort of leveraging assets that they already have in terms of physical plant and land?

Ms. HAMMACK. All of the above.

Senator SCHATZ. Okay.

Ms. HAMMACK. That's the Army strategy.

Mr. ISELIN. Senator, thank you for that question.

I can't speak specifically to the Philippines because I'm not yet read up on those issues. I know that we've recently had an agreement to go to five locations there. I think the predominance were either Air Force or Army support.

But in Darwin, there's ongoing intergovernmental discussions about cost-share arrangements, and those aren't completed yet. So until those are done, I can't comment on specifics.

Certainly, it's in our interests to ensure that there's a fair cost-sharing agreement in place, such that we're not carrying an undue burden.

Ms. BALLENTINE. Senator, the first leg to the Air Force's three-legged military construction stool is to ensure that we are supporting the combatant commanders' (COCOM) military construction requests. And this year, the COCOM support in our MILCON budget is about $293 million, $131 million of that is for Pacific Command (PACOM) projects. And when we look across the FYDP, there are 19 projects in the FYDP to the order of $566 million.

The shift to the Pacific is important to our Nation. It certainly is important to the Air Force and is reflected in our budget.

Senator SCHATZ. Thank you.

And, Mr. Potochney, where are we with cost-sharing arrangements, given these new enterprises?

Mr. POTOCHNEY. Some of them are in negotiation, as you heard, in Australia. But I would highlight what we're doing in Guam. It's almost a $9 billion effort. The Japanese are going to contribute about a third of that, as well as building the Futenma replacement facility, which is completely at their expense.

So there is a fair amount of participation here with our allies.

Senator SCHATZ. Essentially, the Department expects cost-sharing in some form or fashion wherever we are, whether it's a base or rotational force. Is that fair to say?

Mr. POTOCHNEY. Yes.

Senator SCHATZ. Okay.

Mr. POTOCHNEY. Subject to negotiations.

Senator SCHATZ. Sure. I understand it's all negotiated. Some of it is already done, and some of it is pending, and some of it is in the future.

Mr. POTOCHNEY. Right.

Senator SCHATZ. I wanted to talk about the area cost factor. In Hawaii, it costs more than twice what it does to construct a military facility in most places than on the mainland. And I often hear my local commanders say that the area cost factor makes it more difficult for certain projects to compete in the budget process.

Obviously, mission essential projects are going to compete reasonably well. But I worry that others, such as quality-of-life and infrastructure improvement projects are getting pushed to the right or cut entirely.

Mr. Potochney, what guidance has the Department given military services about weighing area cost factors when determining which MILCON projects should be included in their budget requests?

Mr. POTOCHNEY. It is what it is. If it costs us $120 to build something in Hawaii that might cost $100 on the mainland but we need it, it competes for the investment dollars that we have.

Senator SCHATZ. Right. If it is absolutely mission-critical, I have no doubt that we get it, because that's essential. The question becomes if you're talking about the $3 million cap in sustainment, restoration, and modernization (SRM), if you're talking about something that is not absolutely mission critical, I fear that places like Alaska, places like Hawaii, get harmed in that process because things get pushed to the right.

Is that not a concern I should have?

Mr. POTOCHNEY. I think that from what I've seen, based on my experience, is it's worst first. So if we need something, the need competes, and then the resources compete as well. So there is no policy that we put out saying, for instance, let's say with one area, the cost factor is twice as much as somebody else, they should only get half the projects that they need.

However, the fact is, if it's more expensive to build something somewhere, it's tougher to allocate resources to do that. There's nothing anybody can do about that.

But I think, though, that we do have, at least in my view, a fair, equitable, worst-first process.

Senator SCHATZ. Thank you.

Senator KIRK. Senator Hoeven.

Senator HOEVEN. Thank you, Mr. Chairman. I'd like to thank you and the ranking member for calling this hearing today. I appreciate it.

And to all of our witnesses, thank you for being here, and thank you for the good work you do.

My questions are for Assistant Secretary Ballentine. Thanks for being here and, again, for our conversations that we've had on some of these issues previous to this hearing.

But my first question goes to acquisition of helicopters for the missile fields, the three bases that have missile fields, Minot, Malmstrom, and F.E. Warren. Our airmen and -women are still flying Huey helicopters vintage 1969.

They're doing an amazing job, but we need new helicopters. We have the authorization. We have the funding. Now Air Force is working through the process of getting them.

We hope Air Force will piggyback on an Army existing contract, which went through the bid process, so that we can get Blackhawks by 2018 versus 2020 or 2021, if they have to start the whole bidding process over again separately.

What we think Air Force may do is bifurcate that and, at least for the missile fields, go ahead and work with Army. And then they can go ahead through a bid process for the other helicopters, and that would help meet our need.

But it would necessitate some MILCON, probably in 2017, to house the Blackhawks, because the existing facilities aren't large enough.

Now Senator Tester, being really sharp and on the ball, is ahead of the rest of us, so I think Malmstrom is starting in 2017 or they have made arrangements. But certainly for Minot and F.E. Warren, we would need some help there.

So I'm asking what you think the prospects might be to do that.

UH–1N REPLACEMENT MILCON

Ms. BALLENTINE. Thank you, Senator. I would say that you're correct, that the current MILCON program to support the recapitalization of the helicopter is based on our current strategy for acquisition. If that strategy were to change, if the Secretary were to change her strategy for acquisition and move the acquisition to the left in any way, we would need to relook at the out-year military construction programs and/or find mitigations for the in-between

time when the helicopters arrive and when the facilities would be prepared.

Senator HOEVEN. Right. We'll know here pretty soon. I'm hopeful, again, working with Senator Tester and others, we get this done. It's important, I think, for our security police out there.

So we'll know soon, and then we'll come back to you and just ask that you work with us on it. We'll obviously try to help make it happen.

Ms. BALLENTINE. Yes, sir, of course. Thank you.

Senator HOEVEN. The next question really goes to the KC–46 basing decision. It'd be Main Operating Base 4. I anticipate you are starting that process.

Could you tell me about the timeline and anything you can about the process you'll be going through for that basing decision?

KC–46 STRATEGIC BASING PROCESS—MAIN OPERATING BASE FOUR BEDDOWN

Ms. BALLENTINE. Yes, sir.

So in January of this year, we announced the enterprise definition and the criteria for Main Operating Base 4 beddown of the KC–46. The criteria are the same as prior rounds.

We expect in the spring we will have the candidates approved. We are going through the scoring process of the enterprise currently as we speak. And we expect, in the next couple of months, we will have the candidates identified for site visits.

Once those site visits are complete, we would anticipate that this coming winter, the winter of 2016–2017, the Secretary will be able to make a preferred and reasonable alternatives decision.

Then, of course, we need to go through the National Environmental Policy Act (NEPA) process, which puts us into the winter of 2017–2018 for a final basing decision, and we are on track for a spring 2020 beddown of the first aircraft arrival.

Senator HOEVEN. So you were ready for that one. Thank you. I was trying to make notes. Usually, I keep up really well, but that was a great answer. I appreciate it, and I appreciate you moving forward the way you are. That's good.

Along the same lines, my next question relates to remotely piloted aircraft (RPA), and I understand now you're looking at some basing decisions for RPA. And basically, the same question. And then also, what aircraft would you likely be considering? And then the same question as far as timeline, basing decision, and so forth.

RPA WING BEDDOWN

Ms. BALLENTINE. Sure, thank you.

So slightly different timeline for the beddown of the new RPA wing.

As you know, the Air Combat Commander General Carlisle, over the course of the last year, recently did a Culture and Process Improvement study of the MQ–1 and MQ–9 programs, and he recommended a number of changes, including the standup of a new wing, which, of course, triggered a strategic basing process. So let me just walk through the timeline, just like I did for KC–46.

We intend, in the next couple of weeks here, before the spring is out, to be able to announce both the criteria and the enterprise definition for the RPA wing beddown.

And that puts us into the scoring period. And in the summer, we will have the scoring completed. That's the plan.

So we'll be able to announce then the candidates. Then once, of course, the candidates are announced, we'll proceed with the site visits, which puts us into this coming winter, 2016–2017 winter.

We'll be teed up for the Secretary to make a decision for her preferred and reasonable alternatives, which then puts us into the National Environmental Policy Act (NEPA) process over the course of this summer of 2017.

And we would hope to, over the course of summer 2017–2018, depending on how long the NEPA process takes, be able to announce the final beddown location or locations.

Senator HOEVEN. Okay, thank you.

And then just a final comment, and that is that, on the Grand Forks Air Force Base, we have the Grand Sky technology park. It wouldn't happen without your leadership and the leadership of Secretary James, former Assistant Secretary Ferguson, and many others.

So I just want to say to the civilian leadership in Air Force, I really appreciate your good work and how you're going about getting things done and being creative looking to the future, innovative, looking at these public-private partnerships, not only to strengthen the force but to leverage resources at a time when we need to do it.

So again, of course, we appreciate the leadership of our men and women in the Air Force, General Welsh and everybody else. They are fantastic, as they've always been fantastic. But I want to make a special point to thank the civilian leadership in the Air Force as well. We appreciate it very much.

Ms. BALLENTINE. Thank you very much, sir. That's always appreciated to hear.

Senator HOEVEN. Thank you.

Senator KIRK. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

I also want to echo my thanks for all of you being here.

I'm going to start with you, Mr. Potochney, and it deals with the question that Senator Udall raised on a drone that crashed over 2 years ago. The cleanup hasn't been done—Navy mission, Air Force plane, Army site.

The thought occurred thought to me, it's been 2.5 years. I've got a farm. It's in the middle of an Air Force military operations area (MOA)—not in the middle, on the edge of it.

If the same thing would have happened there on private property, would it have been 2 years for the cleanup under the same circumstances? I hope not.

Mr. POTOCHNEY. I hope not as well.

Senator TESTER. So what I would say is that you guys are three branches of the same arm, and it really kind of worries me on different things. I mean, we're fighting a war on terror out there. You guys are in the middle of that. And if we can't work to do some-

thing simple like this, we got problems. So I just want to point that out.

Now I want to talk about the BRAC. All four of you talked about BRAC, so just let me ask you a couple questions. And you can answer a simple yes or no, or however you want to do it.

If we do another round of BRAC, will it improve readiness or will it take away from our readiness?

Mr. POTOCHNEY. I'd say it will improve readiness, yes. It will improve readiness, and I'd be happy to explain why.

Ms. HAMMACK. It'll improve readiness for the Army.

Mr. ISELIN. And the Navy wouldn't support any recommendation that didn't improve readiness.

Senator TESTER. That's good to know.

Ms. BALLENTINE. Absolutely improve readiness.

Senator TESTER. And tell me why, Mr. Potochney.

BRAC

Mr. POTOCHNEY. Well, for one thing, we wouldn't be spending money on facilities that we don't need.

Senator TESTER. Okay.

Mr. POTOCHNEY. That's important.

The second reason is it would allow us to make changes. We have an evolving force structure. We have an evolving threat.

Senator TESTER. Yes.

Mr. POTOCHNEY. Technology changes. We need to adapt to it. And a periodic review of our infrastructure, I think, is a reasonable thing for us to do.

Senator TESTER. Okay.

For the Army, for a BRAC, do you have any idea on how many of your facilities would be mothballed?

Ms. HAMMACK. We do not have an idea, sir, as to the number of facilities that would be mothballed, but our target would be to achieve savings of about $0.5 billion.

Senator TESTER. Over how many years?

Ms. HAMMACK. Over approximately a 5- to 6-year period, so we would expect a return on investment. It is usually stated the kind of return on investment that would be targeted in the BRAC round, but this would be an efficiency BRAC round, not a restructuring BRAC round.

Senator TESTER. Right.

Ms. HAMMACK. We'd be looking at consolidations, which would give us this kind of return on investment and position us for the future that we envision.

Senator TESTER. Okay. So over 5 or 6 years, in the Army's case, you anticipate it would save $500 million.

Ms. HAMMACK. And then it would continue to save $500 million annually.

Senator TESTER. It's $500 million.

Ms. HAMMACK. Million dollars, yes, one-half billion.

Senator TESTER. Okay.

The Navy took severe cuts in previous BRACs. We wouldn't even ask that question of you.

How about the Air Force?

Ms. BALLENTINE. I can't tell you specifically the number of bases we would or will close in the next round of BRAC. I can give you a historic perspective.

Senator TESTER. Yes.

Ms. BALLENTINE. We've never closed more than about 8 percent of our excess capacity, and we've averaged around eight bases per BRAC round, some major, some minor. I should say averaged eight installations, not necessarily full bases, as you think of bases.

Senator TESTER. Right. What kind of savings?

Ms. BALLENTINE. Our returns on investment have averaged between 3 to 5 years, and we would anticipate at least that good this time, because we have such significant excess infrastructure.

We are very supportive of new legislation that would put boundaries on high return on investment.

Senator TESTER. Can you give me a dollar figure?

Mr. POTOCHNEY. Sir, if I could add, for the Department?

Senator TESTER. Sure.

Mr. POTOCHNEY. Based on taking the average of the 1993 and 1995 rounds, which were excess capacity rounds and inflating those dollars up, we're looking at saving across the Department $2 billion a year after they're implemented.

Senator TESTER. $2 billion a year.

Mr. POTOCHNEY. $2 billion a year, and with an investment of approaching $7 billion upfront and then $2 billion a year forever.

Senator TESTER. And the $7 billion would be used for repurposing?

Mr. POTOCHNEY. For repurposing, building the construction at receiving sites, moving people, severance pay, you name it.

Senator TESTER. Okay.

I do have some issues that are more parochial. I will put those forward to you in writing to get back to me. It deals with Malmstrom Air Force Base weapons storage facility, what Senator Hoeven talked about, about the hangars for the helicopters.

I just have one more question for you, Mr. Potochney, and that is, you noted about 12 percent of the DoD facilities were in poor condition, 15 percent in failing condition, that one of four facilities need major repairs or replacement. Even more concerning, you note that a number of facilities slipping from poor to failing is going up instead of going down.

Given the current budget constraints, how does the Department plan to reverse the continuing deterioration of existing facilities and address them in the near term?

Mr. POTOCHNEY. Through the most astute prioritization approach that we can exercise.

Senator TESTER. And do you have that done now?

Mr. POTOCHNEY. We're doing that, and we'll continue to do it. It just becomes more important as our budgets go down.

Senator TESTER. Okay. So we're looking at a budget here, and you're looking at spending it, which is what your job is and it is what our job is.

Mr. POTOCHNEY. Yes, sir.

Senator TESTER. Correct me if I'm out of bounds here, you should have a short- and long-term plan for facilities, and what kind of monies are needed, and where they're needed moving forward. And

I am making the assumption, you correct me if I'm wrong, that this budget is going to address some of both, some of the short-, some of the long-term needs that are out there. Is that correct?

Mr. POTOCHNEY. That's right.

Senator TESTER. And do you feel this budget is adequate?

Mr. POTOCHNEY. No, I do not.

Senator TESTER. How much is it inadequate by?

Mr. POTOCHNEY. I think the services can each tell you what they need to spend above what they could right now. But I would say it's inadequate because we have facilities in failing condition.

Senator TESTER. Domestically.

Mr. POTOCHNEY. Domestic and——

Senator TESTER. And international, too.

Mr. POTOCHNEY. Right.

Senator TESTER. Could you get back to me with an idea on how much this is—I mean, you told me how much we could save with the BRAC. You ought to be able to tell me how much this is underfunded. You can do that. I've got head nods behind you, and probably at the table, too.

So if you could do that, I would appreciate that.

[The information follows:]

The Department of Defense's goal is to fund facilities sustainment at 90 percent of the Facility Sustainment Model forecasted requirement. For fiscal year 2017, the Department would need an additional $1.6 billion to achieve the sustainment goal. Sustainment provides the annual maintenance needs of the real property portfolio. It does not address the growing backlog of maintenance and repairs that have been deferred. The Department's fiscal year 2015 Financial Statement reported its Deferred Maintenance and Repair backlog for real property exceeds $140 billion.

Senator TESTER. I appreciate your guys' commitment to the country. I very much do. And for those of you who served, your service to the country. And thank you for being here today.

Thank you, Mr. Chairman.

Senator KIRK. Peter, let me just follow up with my top priority, making sure that we could withstand or repel a missile attack by Iran against the United States.

My question to you is on the MILCON for Deveselu, Romania, which happens to be right underneath the flight path of a missile aimed at New York from Iran.

Mr. POTOCHNEY. I'm sorry, sir, the question is?

Senator KIRK. I wanted to get an update from you on the MILCON for——

Mr. POTOCHNEY. Can I do that for the record, sir? I would rather give you——

Mr. ISELIN. Sir, I can answer that.

Senator KIRK. Thank you.

Mr. ISELIN. With strong support from the Army Corps of Engineers, those facilities in Romania are complete, and the forces are there.

And your question during your opening remarks about Poland, we expect two MILCONs. One has just been awarded, and the other will be awarded in a couple of months, to get after the facility in Poland.

Senator KIRK. Anybody else? Anything else, Jon?

Senator TESTER. Just thank you all.

Senator KIRK. I think we can wrap up.

Let me thank our witnesses for coming.

And thanks, Senator Tester. I thank all the members of the subcommittee, and say that the record will remain open until the close of business on Tuesday, April 13.

SUBCOMMITTEE RECESS

Senator KIRK. And we will stand adjourned.

[Whereupon, at 11:51 a.m., Thursday, April 7, the subcommittee was recessed, to reconvene at a time subject to the call of the Chair.]

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

WEDNESDAY, JULY 13, 2016

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

The subcommittee met at 10:31 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Mark Kirk (chairman) presiding.

Present: Senators Kirk, Hoeven, Boozman, Capito, Cassidy, Tester, and Udall.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF HON. LAVERNE H. COUNCIL, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY AND CHIEF INFORMATION OFFICER

ACCOMPANIED BY:

DAVID W. WALTMAN, CHIEF INFORMATION STRATEGY OFFICER, VETERANS HEALTH ADMINISTRATION

DR. JONATHAN R. NEBEKER, DEPUTY CHIEF MEDICAL INFORMATION OFFICER, VETERANS HEALTH ADMINISTRATION

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. This hearing is to review the Department's health record and progress towards full interoperability with the Department of Defense (DOD).

Last year for the first time, the GAO put veterans' healthcare on its high risk list for programs that are likely to experience fraud, waste, abuse, and mismanagement. The Government Accountability Office (GAO) cited information technology challenges, one of the five reasons why veterans' healthcare was on this list.

I want to share with you my vision for going forward here, that we are aiming for. Whenever a soldier, sailor, airman leaves Active Duty and becomes a veteran, we should have a 100-percent seamless transmission of their health records to the VA.

Here is a data point. We have about 250,000 servicemembers leave the DOD and become veterans every year. That works out to about 700 per day, a data flow which is well within the possibility of everybody to cover.

We want to make sure there is a seamless continuity of care. I have a friend now who is navigating the Department of Veterans Affairs (VA) disability system, she was deployed in Iraq, and had

38 separate combat events, and wanted to make sure all of those are documented and transferred and are in her disability petition.

Number two, we should also use the combined size of the DOD and VA in the marketplace to establish a worldwide standard for health medical records, encompassing 22 million people. I figure about 2 million come from DOD and 25 million come from VA. To have that 27 million people all as a core of people covered by one electronic health record (EHR) standard, all open source code would allow us to make sure that the industry now has one Federal standard.

The rock candy mountain here is to make sure the system is covering so many patients that the industry follows, and we make sure the medical record industry is established along the lines of a U.S. Code and U.S. standards.

In my State of Illinois, we have Motorola that made the Android System all open source code. Luckily for them, it was the right decision. The marketplace developed 70,000 apps for the Android system to make it the most flexible and user friendly in the world. We want to make sure that open source environment allows us to create medical records for people with U.S. standards.

I think we are on our way towards a several billion dollar industry now based on this work between DOD and VA.

I just talked yesterday with the leading company that is in this space. They told me when I talked with Judy Faulkner who is one of the founders of a company called Epic that now employs 5,000 people in Tammy Baldwin's State—they cover a vast number of the patients' medical records in my State of Illinois.

She said there are really exciting things in this field to gather all those data and do analytics on that. She was particularly excited about Epic's sepsis analytics, which she said could be traced to the saving of 54,000 lives, patients who are liable for sepsis.

Using these analytics, we could reach a new 22nd century level of care for veterans. I want to make sure analytics are a deep part of this electronic healthcare revolution that we have for VA and DOD.

Let me turn it over to my good friend, Mr. Tester.

STATEMENT OF SENATOR JON TESTER

Senator TESTER. Thank you, Mr. Chairman. Thank you for your leadership on this subcommittee. We very much appreciate it. Thank you, Secretary Council, and Ms. Melvin, and Dr. Thompson for being here today for this hearing, I appreciate the work you do.

We all know and we agree that accountability of VA is critically important, whether we are talking about delivering quality and timely care or whether we are talking about IT initiatives such as electronic health records and scheduling systems. We live in the 21st century, and our IT systems should reflect that.

I do look forward to hearing from you about the progress made and the challenges involved with VistA, electronic health record systems, and other key IT programs. We are obviously very interested in the direction VA is heading in terms of modernizing VistA, and whether we are talking about going to a commercial off-the-shelf system or developing a hybrid of the two. Whatever decision is made, we will have long-ranging ramifications not only for the

VA and veterans but also for the American taxpayer who will have to foot this bill.

Although we are focused on electronic health records, we realize that EHR is only one component of a much broader IT modernization effort and conversation. Electronic record sharing is a great asset for both clinicians and patients, but only if the veteran can get an appointment in the first place, and that remains a huge challenge for many veterans in my State and across this country.

In fact, scheduling difficulties are the top complaint that I hear from folks in Montana, and I hear a lot of them. I can tell you that the current system is not going to cut it, so I am concerned that the current medical appointment scheduling system plan is on hold, if it is not the right plan, then it should be revised or replaced, but it cannot be put on the back burner. We need to fix it. We need to fix it today.

So, I look forward to hearing about how the VA is working to devise and implement a better plan, and when that will happen. Cybersecurity is another urgent priority. As the VA's IT system has to provide for greater interoperability among VA providers, private sector providers, and the Department of Defense, cybersecurity must also evolve and adapt.

The challenges facing the VA are formidable, and they are only going to become more complicated with time.

I am also a member of the Senate Veterans' Affairs Committee, and I am proud that Committee has advanced legislation, the Veterans First Act, that includes a lot of critical provisions to empower the VA to better serve our veterans. As we all know, that bill is being held up, just the latest example of Senate dysfunction. Nonetheless, Congress can actually be a constructive partner in this effort.

As the pressure grows on the VA to provide seamless medical record sharing and scheduling, I fully expect you to keep us apprised of your efforts and your challenges. That line of communication is critical as we move forward, and it is critical today.

Again, I want to thank you for your service, and I look forward to hearing your testimony. Once again, thank you, Mr. Chairman.

Senator KIRK. Thank you. We want to welcome our witnesses here. We have Valerie Melvin, the Director of Information Management and Technology Resources Issues at the Government Accountability Office; and Dr. Lauren Thompson, Director of the DOD/VA Interagency Program Office in the Department of Defense; and the Honorable LaVerne Council, with the Department of Veterans Affairs, the VA's Chief Information Officer. We also have Mr. David Waltman and Dr. Jonathan Nebeker, both with the Veterans Health Administration (VHA).

Let's proceed and have Ms. Council begin.

SUMMARY STATEMENT OF HON. LAVERNE H. COUNCIL

Ms. COUNCIL. Chairman Kirk, Ranking Member Tester, distinguished subcommittee members, thank you for the opportunity to discuss how the Office of Information and Technology (OI&T) is transforming technology that we deliver to support our veterans.

I am joined today by Mr. David Waltman, who is VHA's Chief Information Strategy Officer, and Dr. Jonathan Nebeker, VHA's Deputy Chief Medical Informatics Officer.

As described in our media review, we have shifted our focus to outcomes versus activity by emphasizing transparency, accountability, innovation, and team work. We are building on the legacy of VHA innovations and maintaining a united partnership between medicine and technology. Through implementation of a prioritized set of strategic initiatives across our now, near, and future time horizons, we are focused on providing a consistent high quality experience to our users and veterans.

We are evolving into a dynamic proactive posture. We are leaning forward, simplifying and standardizing our infrastructure through buy first and Cloud-based delivery models, utilizing Cloud-based technology will allow us to buy IT services while consolidating our infrastructure and driving the market to facilitate innovation.

Through implementation of our new strategic sourcing function, we will be poised to take advantage of a wealth of innovation that already exists in the marketplace to reduce development overhead costs and speed delivery of services to our veterans.

For the first time, we have IT portfolios in place for all administrations. We have filled all of our new IT account managers or ITAM positions. The ITAMs keep us connected to our partners and ensure that we are meeting their needs.

I am proud to report that over the last year, VA's OI&T's rating was upgraded from 19th to 5th, out of 24 Federal agencies, in the recently released OMB Benchmarks for IT Customer Satisfaction.

We have made strong headway toward modernizing how the VA does business but we are also recognizing that change is not easy and modernization is not a one time act. It requires a relentless focus on execution and constant emphasis on impactful outcomes.

In addition, we are transforming OI&T's leadership team, with 74 percent of OI&T's executive leadership being in new roles or they are new to the agency.

We are on track with our plans to close 100 percent of the Office of Inspector General's (OIG's) 2015 recommendations by the end of 2017, of our Federal Information Security Modernization Act (FISMA) material weakness, and in July 2015, VA had 267,000 accounts with elevated privileges, which allows special access to VA systems. We have reduced that number of accounts by 95.5 percent, exceeding all original expectations.

To reduce complexity and manage access, we are standardizing our device policy to no more than two devices, such as a Smartphone and laptop for each staff member. Since March 2015, our team has identified, corrected and remediated 21 million critical and high vulnerabilities utilizing Nexus monthly scans and enterprise patching.

We have developed an IT/non-IT policy to ensure IT dollars are spent appropriately. We have reduced the number of applications by 500 percent, closing off any potential path for attackers. We have our quality and compliance function, and we are finalizing our governance, structure and strategic sourcing function.

OI&T is committed to safeguarding our veterans' information, and tools, technology, and people of the highest caliber are required. We have increased our cybersecurity funding to $370 million, and I would like to thank this subcommittee for helping us to fully resource our cybersecurity capability for the very first time.

We recognize that effective cybersecurity requires vigilance and a security conscious culture. We take security risks seriously. We are addressing all key FISMA findings, and we are prioritizing our efforts to close the most critical risks first.

We know that a veteran's complete health history is critical to providing seamless, high-quality integrated care and benefits. We are happy to say on April 8, we certified an interoperative with DOD in accordance with the National Defense Authorization Act's (NDAA's) section 713(b)(1), well ahead of the December 2016 deadline.

Last year on July 6, 2015, I was sworn in as the Assistant Secretary and CIO of OI&T. After 1 year, I have learned a lot about the purpose, passion, and drive it takes to make change in a governmental agency. I have also experienced the true grit of the people who are dedicated to the mission of serving our veterans.

Mr. Chairman and members of the subcommittee, thank you again for the opportunity to discuss our progress with you. I look forward to continuing the conversation, and am happy to take any questions you might have at this time.

[The statement follows:]

PREPARED STATEMENT OF HON. LAVERNE H. COUNCIL

Good morning,

Chairman Kirk, Ranking Member Tester, distinguished members of the subcommittee, thank you for the opportunity to discuss the progress that the Department of Veterans Affairs (VA) is making towards modernizing our information technology (IT) infrastructure to provide the best possible service to our VA business partners and our Nation's veterans. I will also discuss scheduling, medical record sharing, and cyber security initiatives at the Department.

In order to successfully carry out these major IT initiatives and the department's consolidation of community care programs, VA will need a digital health platform and IT solutions that will meet the evolving needs of our veterans, as well as support our streamlined business processes.

I am joined by Mr. David Waltman, VHA's Chief Information Strategy Officer, and Dr. Jonathan Nebeker, VHA's Deputy Chief Medical Informatics Officer.

The Veterans Health Administration (VHA) and the Office of Information & Technology (OI&T) are essential partners in delivering quality service to our veterans. Meeting the demands of 21st century veterans requires an interconnected system of systems, based on a single platform, which supports an electronic health record (EHR) as one of several components.

IT plays a critical role in enabling care for our Nation's veterans. VA's current EHR modernization efforts focus on delivering the tools for clinicians to provide more comprehensive, patient-centered care and will support VA's progress to a digital health platform.

We have made substantial progress in delivering new capabilities leveraging VistA, the VA Health System's EHR, while also strategizing for our future needs. Our efforts to modernize the VA's EHR and our plans for the digital health platform are not mutually exclusive. The success of the digital health platform is not dependent on any particular EHR.

VISTA EVOLUTION/INTEROPERABILITY

Current State of VistA Evolution

VistA Evolution is the joint VHA and OI&T program for improving the efficiency and quality of veterans' healthcare by modernizing VA's health information systems, increasing data interoperability with the Department of Defense (DOD) and network

care partners, and reducing the time it takes to deploy new health information management capabilities. We will complete the next iteration of the VistA Evolution Program—VistA 4—in fiscal year 2018, in accordance with the VistA Roadmap and VistA Lifecycle Cost Estimate. VistA 4 will bring improvements in efficiency and interoperability, and will continue VistA's award-winning legacy of providing a safe, efficient healthcare platform for providers and veterans.

VA takes seriously its responsibility as a steward of taxpayer money. Our investments in VistA Evolution continue to make our veterans' EHR system more capable and agile. VA has obligated approximately $510 million in IT Development funds to build critical capabilities into VistA since fiscal year 2014, when Congress first provided specific funding for the VistA Evolution program. In addition, VA has obligated $151 million in IT Sustainment funds and $110 million in VHA funds for VistA Evolution. The VHA funding supports the operational resources needed for requirements development, functional design, content generation, development, training, business process change, and evaluation of health IT systems.

It is important to note that VistA Evolution funding stretches beyond EHR modernization. VistA Evolution funds have enabled critical investments in systems and infrastructure, supporting interoperability, networking and infrastructure sustainment, continuation of legacy systems, and efforts—such as clinical terminology standardization—that are critical to the maintenance and deployment of the existing and future modernized VistA. This work was critical to maintaining our operational capability for VistA. These investments will also deliver value for veterans and VA providers regardless of whether our path forward is to continue with VistA, a shift to a commercial EHR platform as DOD is doing, or some combination of both.

Interoperability

We know that a veteran's complete health history is critical to providing seamless, high-quality integrated care and benefits. Interoperability is the foundation of this capability as it enables clinicians to provide veterans with the most effective care and makes relevant clinical data available at the point of care. Access to accurate veteran information is one of our core responsibilities. The Department is happy to report that, thanks to a joint VA and DOD effort, on April 8, 2016, we jointly certified, to the House and Senate Committees on Appropriations, Armed Services, and Veterans' Affairs that we have met the interoperability requirement of the fiscal year 2014 National Defense Authorization Act (NDAA) Section 713(b)(1). We have not stopped our modernization efforts, as we envision further enhancements that we know are necessary for greater efficiency.

For front-line healthcare teams, the two most exciting products from VistA Evolution are the Joint Legacy Viewer (JLV) and the Enterprise Health Management Platform (eHMP). JLV is a clinical application that provides an integrated, chronological display of health data from VA and DOD providers in a common data viewer. VA and DOD clinicians can use JLV to access, on demand, the health records of veterans and Active Duty and Reserve servicemembers. JLV provides a patient-centric, rather than facility-centric view of health records in near real time. Veterans Benefits Administration (VBA) offices have access to JLV and can use it to expedite claims in certain situations.

As of July 7, 2016, JLV had more than 198,000 authorized users in VA and DOD together, including 158,159 authorized VA users. The team is authorizing several thousand new users in VA each week. In VA, more than 11,000 VBA personnel are authorized to use JLV to help process claims.

The process for granting access to JLV is both simple and secure. JLV allows us to monitor access and usage by capturing logins, records viewed, activities by users, and transactions per hour. In the interest of privacy, security, and safety, JLV is restricted to healthcare providers and benefits administrators. Beneficiaries cannot access JLV, but this in no way affects their rights to copies of their health records upon request. We simultaneously maintain tight controls over the system and ensure efficient access to clinicians and benefits administrators who need it to do their jobs.

JLV has been a critical step in connecting VA and DOD health systems, but it is a read-only application. Building on the interoperability infrastructure supporting JLV, the Enterprise Health Management Platform (eHMP) will ultimately replace our current read-write point of care application. The current application, called the Computerized Patient Record System, or CPRS, has been in use since 1996. CPRS served VA for many years as an industry leading point of care tool for providers, but it has many limitations for modern care delivery.

eHMP will overcome these limitations, and provide a modern web application and clinical data services platform to support veteran-centric, team-based, quality driven

care. eHMP will also natively support interoperability between VA, DOD and community health partners. We are deploying an initial read only version of eHMP now, and will begin deploying eHMP version 2.0 with write-back capabilities in the second quarter of fiscal year 2017. Clinicians will be able to write notes and order laboratory and radiology tests in version 2.0. eHMP 2.0 will also support tasking for team-based management and communication with improved tracking to ensure follow through on tasks.

Veterans will benefit from eHMP in several ways. For example, eHMP will provide a complete view of a veteran's health history from all available VA, DOD and community provider sources of information. This will help providers develop a more complete picture of a veteran's history, enabling better treatment decisions.

The veteran's voice will also be front and center in eHMP. Veterans' goals and preferences for care will become part of the information all providers see. eHMP will also provide a feature dedicated to recording and maintaining a veteran's service history, including duty locations and what type of work they performed during their service. This information could then be used in proactively identifying veterans who may be at risk for certain health issues, or eligible for medical care based on locations or times in which they served.

Veterans will also benefit from VA care teams who can work together more efficiently and effectively using the care coordination and task management tools eHMP will provide. For example, if a veteran is referred for a particular test or consultation with a specialist, workflow management tools in eHMP will ensure the right activities have taken place in advance of the referral. This will help reduce wasted or unneeded appointments, save time for both veterans and providers. In turn, if providers are more efficient, they are able to serve more veterans, which will have an overall positive impact on veteran access to care. All of these efforts align with the goals outlined by the Federal Health Information Technology Strategic Plan 2015—2020 and Connecting Health and Care for a Nation: A Shared Nationwide Interoperability Roadmap, produced by the Office of the National Coordinator for Health Information Technology (ONC) in collaboration with VA, DOD and other partners.

Upon completion, eHMP will support the following capabilities:

—*Veteran-centric healthcare.*—eHMP will allow clinicians to tailor care plans to specific clinical goals and help veterans achieve their healthcare goals.

—*Team-based healthcare.*—eHMP will provide an interoperable care plan in which clinical care team members, including the patient, will understand the goals of care and perform explicit tasks to execute the plan. eHMP will also monitor tasks that are not completed as specified and escalate them to the appropriate team.

—*Quality-driven healthcare.*—eHMP will support the diffusion of best practices, including evidence-based clinical process standardization. eHMP will collect data on how clinicians address conditions and power analytics to generate new evidence for better care and best practices.

—*Improved access to health information.*—eHMP will integrate health data from VA, DOD, and community care partners into a customizable interface that provides a holistic view of each veteran's health records.

Fundamentally, our efforts to improve information systems are about data, not software. Regardless of the software platform, we need to be able to access the right data at the right time. Health data interoperability with DOD and network providers is important— but it is equally important to understand that this is just one aspect of having a comprehensive profile to streamline and unify the veteran experience.

Using eHMP as a tool, healthcare teams will better understand veterans' needs, coordinate care plans, and optimize care intensity in VA and throughout the high-performing network of care.

LOOKING TO THE FUTURE

Modernization is a process, not an end, and the release of VistA 4 in fiscal year 2018 will not be the "end" of VA's EHR modernization. VA has always intended to continue modernizing VA's EHR, beyond VistA 4, with more modern and flexible components.

Technology and clinical capabilities must consistently evolve to meet the growing needs of our veterans. The VistA Evolution program is just that—an evolving capability that is an invaluable part, but not the end of VA's EHR modernization.

Digital Health Platform

Due to the expansion of care in the community, a rapidly growing number of women veterans, and increased specialty care needs, the need for more agility in our EHR has never been greater. We are looking beyond what VistA 4 will deliver in fiscal year 2018, and we are evaluating options for the creation of a Digital Health Platform to ensure that we have the best strategic approach to modernizing our EHR for the next 25 years.

The VA healthcare system must keep the veteran experience at its core and incorporate effective clinical management, hospital operations capability, and predictive analytics. We do not have all of this today with VistA.

To prepare for this new era in connected care, VA is looking beyond the EHR to a digital health platform that can better support veterans throughout the health continuum. These factors drive the need for continuous innovation and press us to plan further into the future.

The EHR is the central component of the digital health platform. However, an EHR by itself does not have all of the capabilities required to manage care in the community, respond to the changing needs of the veteran population, support clinical management, and provide the best overall veteran experience with the VA healthcare system.

We have conducted a business case outlining our vision for the digital health platform. Our goal is to have a modern and integrated healthcare system that would incorporate best-in-class technologies and standards to give it the look, feel, and capabilities users have come to expect in the private sector.

The digital health platform will be agile, and will leverage international open-source standards such as the Fast Healthcare Interoperability Resources (FHIR) framework.

FHIR converts granular health data points into standardized data formats already well known to healthcare IT application developers. The main goal of FHIR is to simplify implementation without sacrificing information integrity. VA is working with standards organizations and industry partners to further refine FHIR to allow the level of interoperability necessary for the functionality described above.

Health Level 7 International (HL7), a not-for-profit American National Standards Institute (ANSI)-certified standards developing organization, developed FHIR. HL7 has produced healthcare data exchange and information modeling standards since its founding in 1987. Emerging industry practices and lessons learned from previous standards frameworks informed HL7's development of FHIR.

The digital health platform will be a system of systems. It is not dependent on any particular EHR, and VA can integrate new or existing resources into the system without sacrificing data interoperability. One of the digital health platform's defining features will be system-wide cloud integration, a marked improvement over the more than 130 instances of VistA that we have today.

OI&T and VHA have agreed upon a strategy to guide the formal planning of modernizing VA healthcare delivery beyond the conclusion of VistA 4 in fiscal year 2018. Our vision calls for a digital health platform that will go beyond EHR modernization to create a better overall experience for the veteran throughout the continuum of care. We continue to work closely with VHA to formulate our approach and apply the rigor of formalized program planning, and will keep this subcommittee updated as the process unfolds.

SCHEDULING

We recognize the urgent need for improvement in VA's appointment scheduling system. We are evaluating the Veteran Appointment Request (VAR) application and the VistA Scheduling Enhancement (VSE) through simultaneous pilot programs. We are testing VAR at two facilities. We have been testing VSE at 10 locations, and are in the training phase for national deployment of VSE.

VAR is a new veteran facing capability allowing veterans to directly request primary care and mental health appointments as face-to-face, telephone, or video visits by specifying three desired appointment dates. The software allows established primary care patients to schedule and cancel primary care appointments directly with their already-assigned Patient Aligned Care Team provider.

We are testing VAR at two facilities in the VA New England Health System (Veterans Integrated Service Network (VISN) 1)—the VA Connecticut Healthcare System (West Haven) and the VA Boston Healthcare System (Jamaica Plain).

VSE updates the legacy command line scheduling application with a modern graphical user interface. This capability reduces the time it takes schedulers to enter new appointments, and makes it easier to see provider availability. VSE provides critical, near-term enhancements, including a graphical user interface, aggre-

gated facility views, profile scheduling grids, single queues for appointment requests, and resource management reporting.

Our 10 VSE Initial Operational Capability sites are:

1. Charles George VA Medical Center in Asheville, North Carolina
2. West Palm Beach VA Medical Center in West Palm Beach, Florida
3. Chillicothe VA Medical Center in Chillicothe, Ohio
4. VA Hudson Valley Health Care System in New York
5. Louis Stokes Cleveland VA Medical Center in Cleveland, Ohio
6. VA New York Harbor Health Care System in New York, New York
7. VA Salt Lake City Health Care System in Utah
8. VA Southern Arizona Health Care System in Tucson, Arizona
9. James H. Quillen VA Medical Center in Mountain Home, Tennessee
10. Washington, DC VA Medical Center in Washington, DC

VA schedulers tell us that they need a system focused purely on scheduling. VSE and VAR pilots are available now and show positive results in meeting the business requirements of our partners. In contrast, the Medical Appointment Scheduling System (MASS) project includes additional features that add complexity, leading us to put MASS on a strategic hold while our team ensures that we meet all requirements without undue processing difficulties. VA will carefully measure the results of the VSE pilot to determine the best use of resources that will meet veteran needs. VA is working hard to ensure that every technological tool and improvement makes judicious use of taxpayer dollars while providing solutions that support today's veterans' needs.

ENTERPRISE CYBERSECURITY STRATEGY

OI&T is facing the ever-growing cyber threat head on—we are committed to protecting all veteran information and VA data and limiting access to only those with the proper authority. This commitment requires us to think enterprise-wide about security holistically. We have dual responsibility to store and protect veterans records, and our strategy addresses both privacy and security.

In order to achieve and maintain the highest level of security, we need the active participation of everyone who accesses VA systems. We are providing comprehensive education to ensure that all VA employees remain vigilant. We have updated our National Rules of Behavior and our annual security training, and we are emphasizing continuous engagement with our employees. Information security poses constant challenges, and it is only through continuous reinforcement that our employees can support us in this battle.

The first step in our transformation was addressing enterprise cyber security. We delivered an actionable, far-reaching, cybersecurity strategy and implementation plan for VA to Congress on September 28, 2015, as promised. We designed our strategy to counter the spectrum of threat profiles through a multi-layered, in-depth defense model enabled through five strategic goals.

—*Protecting Veteran Information and VA Data:* We are strongly committed to protecting data. Our data security approach emphasizes in-depth defense, with multiple layers of protection around all veteran and VA data.

—*Defending VA's Cyberspace Ecosystem:* Providing secure and resilient VA information systems technology, business applications, publically accessible platforms, and shared data networks is central to VA's ability to defend VA's cyberspace ecosystem. Addressing technology needs and operations that require protection, rapid response protocols, and efficient restoration techniques is core to effective defense.

—*Protecting VA Infrastructure and Assets:* Protecting VA infrastructure requires going beyond the VA-owned and VA-operated technology and systems within VA facilities to include the boundary environments that provide potential access and entry into VA by cyber adversaries.

—*Enabling Effective Operations:* Operating effectively within the cyber sphere requires improving governance and organizational alignment at enterprise, operational, and tactical levels (points of service interactions). This requires VA to integrate its cyberspace and security capabilities and outcomes within larger governance, business operation, and technology architecture frameworks.

—*Recruiting and Retaining a Talented Cybersecurity Workforce:* Strong cybersecurity requires building a workforce with talent in cybersecurity disciplines to implement and maintain the right processes, procedures, and tools.

VA's Enterprise Cybersecurity Strategy is a major step forward in VA's commitment to safeguarding veteran information and VA data within a complex environment. The strategy establishes an ambitious yet carefully crafted approach to

cybersecurity and privacy protections that enable VA to execute its mission of providing quality healthcare, benefits, and services to veterans, while delivering on our promise to keep veteran information and VA data safe and secure.

In addition, we have a large legacy issue that we need to address. In the fiscal year 2017 budget request, VA ha increased requested spending on security to $370 million, fully funding and fully resourcing our security capability for the first time. We are committed to eliminating our material weakness in fiscal year 2017, and these funds are enabling those efforts. In addition, VA is investing over $50 million to create a data-management backbone. I want to thank this subcommittee for fully funding the President's request in this area.

IT TRANSFORMATION AND ENTERPRISE PROGRAM MANAGEMENT OFFICE

OI&T is transforming. Persistent internal challenges exist in delivering IT services, and external pressures have compelled us to change and adapt. Through the MyVA initiative, VA is modernizing its culture, processes, and capabilities to put veterans first, and is giving our team the opportunity to make a real difference in veterans' lives. This momentum is driving us to transform OI&T on behalf of our partners, our employees, and veterans.

EPMO is building our momentum in OI&T's transformation. EPMO hosts our biggest IT programs, including the Veterans Health Information Systems and Technology Architecture (VistA) Evolution, Interoperability, the Veterans Benefits Management System, and Medical Appointment Scheduling System (MASS). EPMO also supports the Federal Information Technology Acquisition Reform Act (FITARA) requirements.

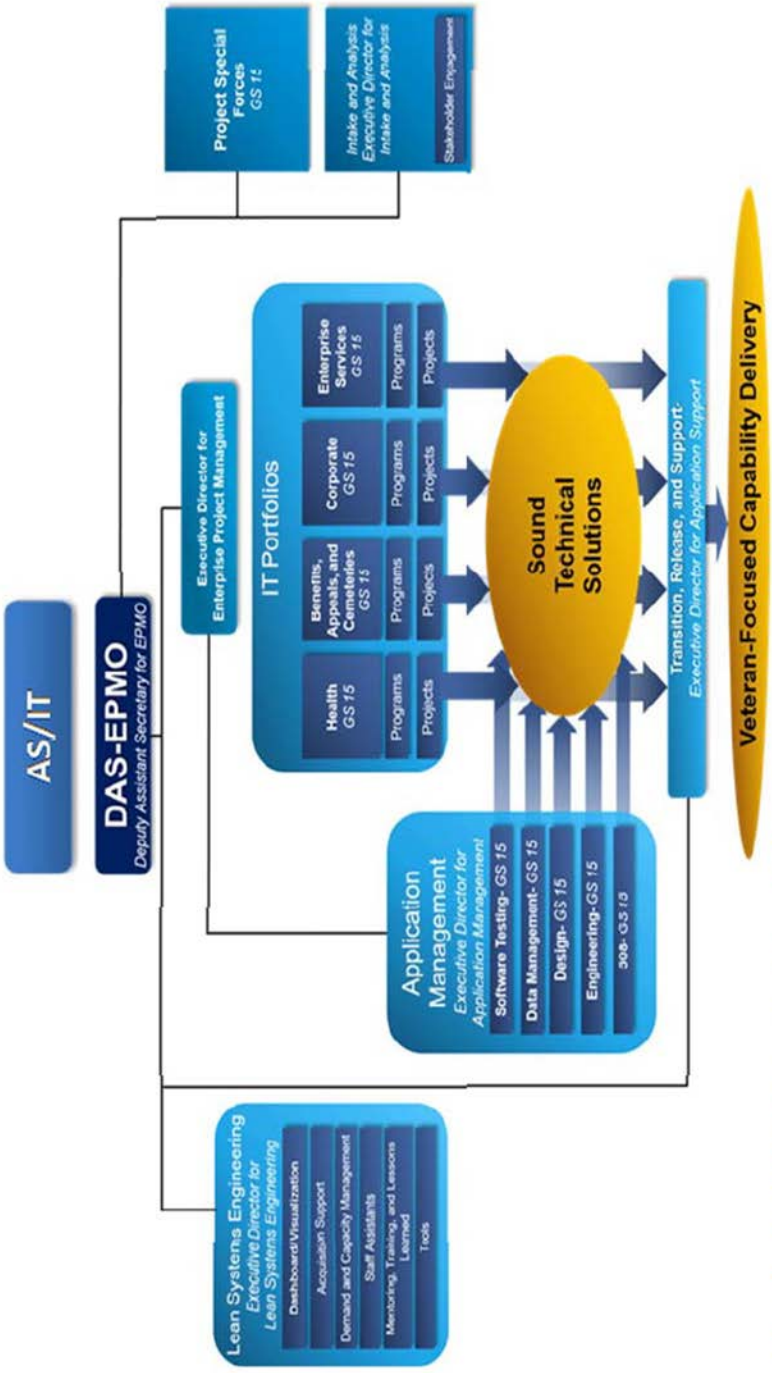

Fig. 1 – EPMO Organizational Chart

EPMO ensures alignment of program portfolios to strategic objectives and provides visibility and governance into the programs.

For enterprise initiatives, EPMO helps program and project teams to better develop execution plans, monitor progress, and report the status of these programs and projects. EPMO enables partnerships with IT architects for enterprise collaboration and serves as a program/project resource for the delivery of enterprise and cross-functional programs. This helps identify Shared Services Enterprise Programs and will help plan resource requirements with portfolios and architecture.

EPMO has already produced results. The Veteran-focused Integration Process (VIP) is a project-level based process that replaces the Program Management Accountability System (PMAS). VIP streamlines IT product release activities and increases the speed of delivering high-quality, secure capabilities to veterans. VIP is revolutionary because it utilizes a single release process—designed to eliminate redundancy in review, approval, and communications—that all VA organizations will follow by the end of 2016. These releases are scheduled on a 3-month cadence—an improvement over the previous 6-month standard—and allow greatly needed IT services to be delivered to veterans more frequently.

VIP reduces overhead and is more efficient and cost effective than PMAS. VIP's efficiencies include reducing the review process from 10 independent groups with 90 people to a single group of 30 people focused on ensuring that products meet specified, consistent criteria for release.

VIP focuses on *doing* rather than *documenting,* with a reduction of artifacts from more than 50 to just 7, plus the Authority to Operate, and the shift from a 6-month to a 3-month delivery cycle. Further, as a guarantee to our work, EPMO will ensure that product teams stay assigned to their projects for at least 90 days after the final deployment.

CONCLUSION

VA is at a historic crossroad and will need to make bold reforms that will shape how we deliver IT services and healthcare in the future, as well as improve the experiences of veterans, community providers, and VA staff. Throughout this transformation, our number one priority has and will always be the veteran—ensuring a safe and secure environment for their information and improving their experience is our goal.

As with all issues, VA strongly values the input and support of all its stakeholders. We realize the vital role they play in assisting us in providing timely, high-quality care to veterans, and we look forward to continued open dialogue.

This concludes my testimony, and I am happy to answer your questions.

Senator KIRK. Thank you. We will hear from Valerie Melvin, Director, Information Management and Technology Resources Issues, U.S. Government Accountability Office.

GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF VALERIE C. MELVIN, DIRECTOR, INFORMATION MANAGEMENT AND TECHNOLOGY RESOURCES ISSUES

Ms. MELVIN. Good morning, Chairman Kirk, Ranking Member Tester, and members of the subcommittee. Thank you for inviting me to testify today. VA's electronic health records system, VistA, is essential to the healthcare of veterans, and the Department has been taking steps over many years toward modernizing the system.

Also, for almost two decades, it has been working with DOD to advance electronic health record interoperability between their systems. However, while the Department has made progress in these efforts, significant IT challenges have contributed to our designating VA's healthcare as high risk, as you mentioned earlier.

At your request, my testimony today summarizes key findings and concerns about the Department's efforts based on previous reports that we have issued and VA's actions in response to our recommendations.

With regard to electronic health record interoperability, we have consistently pointed to a troubled path toward achieving this capability. Since 1998, VA has undertaken a patchwork of initiatives with DOD to increase health information exchange between their systems. These efforts have yielded increasing amounts of standardized health data, and made an integrated view of the data available to clinicians.

Nevertheless, a modernized VA electronic health record system that is fully interoperable with DOD's system is still years away.

In 2011, VA and DOD announced that they would develop one integrated system to replace both Departments' separate systems, and thus sidestep many of their previous challenges to achieving interoperability. However, after 2 years and approximately $564 million reportedly spent, the Departments abandoned this plan, saying separate systems with interoperable capabilities between them could be achieved faster and at less overall cost.

Yet, as VA and DOD have proceeded on separate paths, we have continued to highlight three primary concerns with their approach. First, the Departments have lacked outcome-oriented goals and metrics to clearly define what they aim to achieve from their interoperability efforts. Thus, an important question remains as to when VA intends to define the extent of interoperability it needs to provide the highest quality of patient care, and when the Department intends to achieve this with DOD.

VA concurred with our recommendation that it develop such goals and metrics, and subsequently said it is defining an approach for identifying health outcome-oriented metrics and baseline measurements.

Second, VA's plan to modernize VistA raises concerns about duplication with DOD's system acquisition. The Departments have identified 10 areas in which they have common healthcare business needs, and a study has identified over 97 percent of inpatient requirements for electronic health record systems as being common to both Departments.

Further, despite our recommending that it do so, VA has yet to substantiate its claim that modernizing VistA, together with DOD acquiring a new system, can be achieved faster and at less cost than a single joint system. Thus, an important question that remains as to how VA and DOD can continue to justify the need for separate systems.

Finally, while VA has begun implementing VistA modernization plans, it is doing so amid uncertainty about its approach. A recent independent assessment of its health IT raised questions about the lack of any clear advances in the Department's efforts over the past decade, and recommended that VA assess its alternatives for delivering modernized capabilities.

Nevertheless, the Under Secretary for Health has maintained that the Department is following through with plans to complete a modernized system in fiscal year 2018, while the CIO has indicated that VA is reconsidering how best to meet its needs.

Thus, with regard to VA's electronic health record interoperability and system modernization efforts, uncertainty and important questions remain about what the Department is prepared to accomplish, in what timeframes, and at what costs.

This concludes my oral statement. I would be pleased to respond to your questions.

[The statement follows:]

PREPARED STATEMENT OF VALERIE C. MELVIN

GAO HIGHLIGHTS

Highlights of GAO–16–807T, a testimony before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, U.S. Senate.

WHY GAO DID THIS STUDY

VA operates one of the Nation's largest healthcare systems, serving millions of veterans each year. For almost two decades, the department has undertaken a patchwork of initiatives with DOD to increase interoperability between their respective electronic health record systems. During much of this time, VA has also been planning to modernize its system. While the department has made progress in these efforts, it has also faced significant information technology challenges that contributed to GAO's designation of VA healthcare as a high risk area.

This statement summarizes GAO's August 2015 report (GAO–15–530) on VA's efforts to achieve interoperability with DOD's electronic health records system. It also summarizes key content from GAO's reports on duplication, overlap, and fragmentation of Federal Government programs. Lastly, this statement provides updated information on VA's actions in response to GAO's recommendation calling for an interoperability and electronic health record system plan.

WHAT GAO RECOMMENDS

In prior reports, GAO has made numerous recommendations to VA to improve the modernization of its IT systems. Among other things, GAO has recommended that VA address challenges associated with interoperability, develop goals and metrics to determine the extent to which the modernized systems are achieving interoperability, and address shortcomings with planning. VA generally agreed with GAO's recommendations.

View GAO–16–807T. For more information, contact Valerie C. Melvin at (202) 512-6304 melvinv@gao.gov.

ELECTRONIC HEALTH RECORDS

VA'S EFFORTS RAISE CONCERNS ABOUT INTEROPERABILITY GOALS AND MEASURES, DUPLICATION WITH DOD, AND FUTURE PLANS

WHAT GAO FOUND

Even as the Department of Veterans Affairs (VA) has undertaken numerous initiatives with the Department of Defense (DOD) that were intended to advance the ability of the two departments to share electronic health records, the departments have not identified outcome-oriented goals and metrics to clearly define what they aim to achieve from their interoperability efforts. In an August 2015 report, GAO recommended that the two departments establish a timeframe for identifying outcome-oriented metrics, define related goals as a basis for determining the extent to which the departments' systems are achieving interoperability, and update their guidance accordingly. Since that time, VA has established a performance architecture program that has begun to define an approach for identifying outcome-oriented metrics focused on health outcomes in selected clinical areas and has begun to establish baseline measurements. GAO is continuing to monitor VA's and DOD's efforts to define metrics and report on the interoperability results achieved between the departments.

Following an unsuccessful attempt to develop a joint system with DOD, VA switched tactics and moved forward with an effort to modernize its current system separately from DOD's planned acquisition of a commercially available electronic health record system. The department took this course of action even though, in May 2010, it identified 10 areas of healthcare business needs in common with those of DOD. Further, the results of a 2008 study pointed out that more than 97 percent of inpatient requirements for electronic health record systems are common to both departments. GAO noted that the departments' plans to separately modernize their systems were duplicative and recommended that their decisions should be justified

by comparing the costs and schedules of alternate approaches. The departments agreed with GAO's recommendations and stated that their initial comparison indicated that separate systems would be more cost effective. However, the departments have not provided a comparison of the estimated costs of their current and previous approaches. Further, both departments developed schedules that indicated their separate modernization efforts will not be completed until after the 2017 planned completion date for the previous joint system approach.

VA has developed a number of plans to support its development of its electronic health record system, called VistA, including a plan for interoperability and a road map describing functional capabilities to be deployed through fiscal year 2018. According to the road map, the first set of capabilities was delivered by the end of September 2014 and included a foundation for future functionality, such as an enhanced graphical user interface and enterprise messaging infrastructure. However, a recent independent assessment of health information technology (IT) at VA reported that lengthy delays in modernizing VistA had resulted in the system becoming outdated. Further, this study questioned whether the modernization program can overcome a variety of risks and technical issues that have plagued prior VA initiatives of similar size and complexity. Although VA's Under Secretary for Health has asserted that the department will complete the VistA Evolution program in fiscal year 2018, the Chief Information Officer has indicated that the department is reconsidering how best to meet its future electronic health record system needs.

Chairman Kirk, Ranking Member Tester, and members of the subcommittee:

Thank you for inviting me to testify at today's hearing on the Department of Veterans Affairs' (VA) electronic health record system—the Veterans Health Information Systems and Technology Architecture (VistA)—and the department's progress toward achieving interoperability with the Department of Defense (DOD). For almost two decades, VA has been working with DOD to advance electronic health record interoperability between their systems, in an attempt to achieve the seamless sharing of healthcare data and make patient data more readily available to healthcare providers, reduce medical errors, and streamline administrative functions. Also, for much of this same time period, VA has been planning and taking steps toward the modernization of its electronic health record system, with the intent of ensuring that the department can effectively deliver care for the millions of veterans and others that it serves.

Since 2001, we have issued a number of reports that addressed VA's progress, in conjunction with DOD, toward achieving interoperable electronic health records between their separate systems,[1] as well as its project with DOD to jointly develop a shared electronic health record system.[2] In addition, we have reported on actions that VA has taken with regard to modernizing its electronic health record system.[3] While the department has made progress in these efforts, it has also faced significant information technology challenges that contributed to our designation of VA healthcare as a high risk area.[4]

At your invitation, my testimony today summarizes our key findings and concerns from this overall body of work. Specifically, in developing this testimony, we relied on our previous reports, as well as information that we obtained and reviewed on VA's actions in response to our previous recommendations. The reports cited throughout this statement include detailed information on the scope and methodology for our reviews.

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[1] GAO, *Electronic Health Records: Outcome-Oriented Metrics and Goals Needed to Gauge DOD's and VA's Progress in Achieving Interoperability,* GAO–15–530 (Washington, D.C.: Aug. 13, 2015); *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue,* GAO–11–318SP (Washington, D.C.: Mar. 1, 2011); *Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs,* GAO–11–265 (Washington, D.C.: Feb. 2, 2011); *Electronic Health Records: DOD and VA Interoperability Efforts are Ongoing; Program Office Needs to Implement Recommended Improvements,* GAO–10–332 (Washington, D.C.: Jan. 28, 2010); *Electronic Health Records: DOD and VA Have Increased Their Sharing of Health Information, but More Work Remains,* GAO–08–954, (Washington, D.C.: July 28, 2008); and *Computer-Based Patient Records: Better Planning and Oversight By VA, DOD, and IHS Would Enhance Health Data Sharing,* GAO–01–459 (Washington, D.C.: Apr. 30, 2001).

[2] GAO, *Electronic Health Records: VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration,* GAO–14–302 (Washington, D.C.: Feb. 27, 2014).

[3] GAO, *Veterans Affairs: Health Information System Far from Complete; Improved Project Planning and Oversight Needed,* GAO–08–805 (Washington, D.C.: Jun. 30, 2008).

[4] GAO, *High Risk Series: An Update,* GAO–15–290 (Washington, D.C.: Feb. 11, 2015).

The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

BACKGROUND

VA operates one of the largest healthcare systems in America, providing care to millions of veterans and their families each year. The department's health information system—VistA—serves an essential role in helping the department to fulfill its healthcare delivery mission. Specifically, VistA is an integrated medical information system that was developed in-house by the department's clinicians and information technology (IT) personnel, and has been in operation since the early 1980s.[5] The system consists of 104 separate computer applications, including 56 health provider applications; 19 management and financial applications; 8 registration, enrollment, and eligibility applications; 5 health data applications; and 3 information and education applications. Within VistA, an application called the Computerized Patient Record System enables the department to create and manage an individual electronic health record for each VA patient.

Electronic health records are particularly crucial for optimizing the healthcare provided to veterans, many of whom may have health records residing at multiple medical facilities within and outside the United States. Taking these steps toward interoperability—that is, collecting, storing, retrieving, and transferring veterans' health records electronically—is significant to improving the quality and efficiency of care. One of the goals of interoperability is to ensure that patients' electronic health information is available from provider to provider, regardless of where it originated or resides.

Since 1998, VA has undertaken a patchwork of initiatives with DOD to allow the departments' health information systems to exchange information and increase interoperability.[6] Among others, these have included initiatives to share viewable data in the two departments' existing (legacy) systems, link and share computable data between the departments' updated heath data repositories, and jointly develop a single integrated system that would be used by both departments. Table 1 summarizes a number of these key initiatives.

TABLE 1: HISTORY OF THE DEPARTMENTS OF VETERANS AFFAIRS' AND DEFENSE'S ELECTRONIC HEALTH RECORD INTEROPERABILITY INITIATIVES

Initiative	Year begun	Description
Government Computer-Based Patient Record.	1998	This interface was expected to compile requested patient health information in a temporary, ''virtual'' record that could be displayed on a user's computer screen.
Federal Health Information Exchange.	2002	The Government Computer-Based Patient Record initiative was narrowed in scope to focus on enabling the Department of Defense (DOD) to electronically transfer service members' health information to the Department of Veterans Affairs (VA) upon their separation from active duty. The resulting initiative, completed in 2004, was renamed the Federal Health Information Exchange. This capability is currently used by the departments to transfer data from DOD to VA.
Bidirectional Health Information Exchange.	2004	This capability provides clinicians at both departments with viewable access to records on shared patients. It is currently used by VA and DOD to view data stored in both departments' heath information systems.
Clinical Data Repository/Health Data Repository Initiative.	2004	This interface links DOD's Clinical Data Repository and VA's Health Data Repository to achieve a two-way exchange of health information.

[5] VistA began operation in 1983 as the Decentralized Hospital Computer Program. In 1996, the name of the system was changed to VistA.

[6] DOD uses a separate electronic health record system, the Armed Forces Health Longitudinal Technology Application, which consists of multiple legacy medical information systems developed from customized commercial software applications.

TABLE 1: HISTORY OF THE DEPARTMENTS OF VETERANS AFFAIRS' AND DEFENSE'S ELECTRONIC HEALTH RECORD INTEROPERABILITY INITIATIVES—Continued

Initiative	Year begun	Description
Virtual Lifetime Electronic Record.	2009	To streamline the transition of electronic medical, benefits, and administrative information between the departments, this initiative enabled access to electronic records for service members as they transition from military to veteran status and throughout their lives. It also expands the departments' health information-sharing capabilities by enabling access to private-sector health data.
Joint Federal Health Care Center.	2010	The Captain James A. Lovell Federal Health Care Center was a 5-year demonstration project to integrate DOD and VA facilities in the North Chicago, Illinois, area. It is the first integrated Federal healthcare center for use by beneficiaries of both departments, with an integrated DOD–VA workforce, a joint funding source, and a single line of governance.

Source: GAO summary of prior work and department documentation | GAO–16–807T.

In addition to the initiatives mentioned in table 1, VA has worked in conjunction with DOD to respond to provisions in the *National Defense Authorization Act for fiscal year 2008,*[7] which required the departments to jointly develop and implement fully interoperable electronic health record systems or capabilities in 2009. Yet, even as the departments undertook numerous interoperability and modernization initiatives, they faced significant challenges and slow progress. For example, VA's and DOD's success in identifying and implementing joint IT solutions has been hindered by an inability to articulate explicit plans, goals, and timeframes for meeting their common health IT needs.

In March 2011, the secretaries of VA and DOD announced that they would develop a new, joint integrated electronic health record system (referred to as iEHR). This was intended to replace the departments' separate systems with a single common system, thus sidestepping many of the challenges they had previously encountered in trying to achieve interoperability. However, in February 2013, about 2 years after initiating iEHR, the secretaries announced that the departments were abandoning plans to develop a joint system, due to concerns about the program's cost, schedule, and ability to meet deadlines. The Interagency Program Office (IPO), put in place to be accountable for VA's and DOD's efforts to achieve interoperability,[8] reported spending about $564 million on iEHR between October 2011 and June 2013.

In light of VA and DOD not implementing a solution that allowed for the seamless electronic sharing of healthcare data, the *National Defense Authorization Act for fiscal year 2014*[9] included requirements pertaining to the implementation, design, and planning for interoperability between the departments' electronic health record systems. Among other actions, provisions in the act directed each department to (1) ensure that all healthcare data contained in their systems (VA's VistA and DOD's Armed Forces Health Longitudinal Technology Application, referred to as AHLTA) complied with national standards and were computable in real time by October 1, 2014; and (2) deploy modernized electronic health record software to support clinicians while ensuring full standards-based interoperability by December 31, 2016.

In August 2015, we reported that VA, in conjunction with DOD, had engaged in several near-term efforts focused on expanding interoperability between their existing electronic health record systems. For example, the departments had analyzed data related to 25 "domains" identified by the Interagency Clinical Informatics Board and mapped health data in their existing systems to standards identified by the IPO. The departments also had expanded the functionality of their Joint Legacy Viewer—a tool that allows clinicians to view certain healthcare data from both departments in a single interface.

More recently, in April 2016, VA and DOD certified that all healthcare data in their systems complied with national standards and were computable in real time. However, VA acknowledged that it did not expect to complete a number of key ac-

[7] Public Law No. 110–181, § 1635, 122 Stat. 3, 460–463 (2008).

[8] The *National Defense Authorization Act for fiscal year 2008* called for the departments to set up an interagency program office to be a single point of accountability to implement fully interoperable electronic health record systems or capabilities by September 30, 2009. This office was chartered in January 2009.

[9] Public Law No. 113–66, Div. A, Title VII, § 713, 127 Stat. 672, 794–798 (Dec. 26, 2013).

tivities related to its electronic health record system until sometime after the December 31, 2016, statutory deadline for deploying modernized electronic health record software with interoperability. Specifically, the department stated that deployment of a modernized VistA system at all locations and for all users is not planned until 2018.

TOGETHER WITH DOD AND THE INTERAGENCY PROGRAM OFFICE, VA NEEDS TO DEVELOP GOALS AND METRICS FOR ASSESSING INTEROPERABILITY

Even as VA has undertaken numerous initiatives with DOD that were intended to advance electronic health record interoperability, a significant concern is that these departments have not identified outcome-oriented goals and metrics to clearly define what they aim to achieve from their interoperability efforts, and the value and benefits these efforts are expected to yield. As we have stressed in our prior work and guidance,[10] assessing the performance of a program should include measuring its outcomes in terms of the results of products or services. In this case, such outcomes could include improvements in the quality of healthcare or clinician satisfaction. Establishing outcome-oriented goals and metrics is essential to determining whether a program is delivering value.

The IPO is responsible for monitoring and reporting on VA's and DOD's progress in achieving interoperability and coordinating with the departments to ensure that these efforts enhance healthcare services. Toward this end, the office issued guidance that identified a variety of process-oriented metrics to be tracked, such as the percentage of health data domains that have been mapped to national standards. The guidance also identified metrics to be reported that relate to tracking the amounts of certain types of data being exchanged between the departments, using existing capabilities. This would include, for example, laboratory reports transferred from DOD to VA via the Federal Health Information Exchange and patient queries submitted by providers through the Bidirectional Health Information Exchange.

Nevertheless, in our August 2015 report, we noted that the IPO had not specified outcome-oriented metrics and goals that could be used to gauge the impact of the interoperable health record capabilities on the departments' healthcare services. At that time, the acting director of the IPO stated that the office was working to identify metrics that would be more meaningful, such as metrics on the quality of a user's experience or on improvements in health outcomes. However, the office had not established a timeframe for completing the outcome-oriented metrics and incorporating them into the office's guidance.

In the report, we stressed that using an effective outcome-based approach could provide the two departments with a more accurate picture of their progress toward achieving interoperability, and the value and benefits generated. Accordingly, we recommended that the departments, working with the IPO, establish a timeframe for identifying outcome- oriented metrics; define related goals as a basis for determining the extent to which the departments' modernized electronic health record systems are achieving interoperability; and update IPO guidance accordingly.

Both departments concurred with our recommendations. Further, since that time, VA has established a performance architecture program that has begun to define an approach for identifying outcome-oriented metrics focused on health outcomes in selected clinical areas, and it also has begun to establish baseline measurements. We intend to continue monitoring the department's efforts to determine how these metrics define and report on the results achieved by interoperability between the departments.

VA'S PLAN TO MODERNIZE VISTA RAISES CONCERN ABOUT DUPLICATION WITH DOD'S ELECTRONIC HEALTH RECORD SYSTEM ACQUISITION

Following the termination of the iEHR initiative, VA moved forward with an effort to modernize VistA separately from DOD's planned acquisition of a commercially available electronic health record system. The department took this course of action even though it has many healthcare business needs in common with those of DOD. For example, in May 2010, VA (and DOD) issued a report on medical IT to Congressional committees that identified 10 areas—inpatient documentation, outpatient documentation, pharmacy, laboratory, order entry and management, sched-

[10] GAO, *Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care,* GAO–14–207 (Washington, D.C.: March 6, 2014); *Designing Evaluations: 2012 Revision,* GAO–12–208G (Washington, D.C.: Jan. 31, 2012); *Performance Measurement and Evaluation: Definitions and Relationships,* GAO–11–646SP (Washington, D.C.: May 2, 2011); and *Executive Guide: Effectively Implementing the Government Performance and Results Act,* GAO/GGD–96–118 (Washington, D.C.: June 1, 1996).

uling, imaging and radiology, third-party billing, registration, and data sharing—in which the departments have common business needs.[11] Further, the results of a 2008 study pointed out that over 97 percent of inpatient requirements for electronic health record systems are common to both departments.[12]

We also issued several prior reports regarding the plans for separate systems, in which we noted that the departments did not substantiate their claims that VA's VistA modernization, together with DOD's acquisition of a new system, would be achieved faster and at less cost than developing a single, joint system. Moreover, we noted that the departments' plans to modernize their two separate systems were duplicative and stressed that their decisions should be justified by comparing the costs and schedules of alternate approaches.[13]

We recommended that VA and DOD develop cost and schedule estimates that would include all elements of their approach (i.e., modernizing both departments' health information systems and establishing interoperability between them) and compare them with estimates of the cost and schedule for developing a single, integrated system. If the planned approach for separate systems was projected to cost more or take longer, we recommended that the departments provide a rationale for pursuing such an approach.

VA, as well as DOD, agreed with our recommendations and stated that an initial comparison had indicated that the approach involving separate systems would be more cost effective. However, as of June 2016, the departments had not provided us with a comparison of the estimated costs of their current and previous approaches. Further, with respect to their assertions that separate systems could be achieved faster, both departments had developed schedules which indicated that their separate modernization efforts are not expected to be completed until after the 2017 planned completion date for the previous single-system approach.

VA HAS BEGUN TO IMPLEMENT VISTA MODERNIZATION PLANS AMID UNCERTAINTY ABOUT ITS APPROACH; THE DEPARTMENT IS CURRENTLY RECONSIDERING HOW TO PROCEED

As VA has proceeded with its program to modernize VistA (known as VistA Evolution), the department has developed a number of plans to support its efforts. These include an interoperability plan and a road map describing functional capabilities to be deployed through fiscal year 2018. Specifically, these documents describe the department's approach for modernizing its existing electronic health record system through the VistA Evolution program, while helping to facilitate interoperability with DOD's system and the private sector. For example, the VA *Interoperability Plan,* issued in June 2014, describes activities intended to improve VistA's technical interoperability,[14] such as standardizing the VistA software across the department to simplify sharing data.

In addition, the *VistA 4 Roadmap,* last revised in February 2015, describes four sets of functional capabilities that are expected to be incrementally deployed during fiscal years 2014 through 2018 to modernize the VistA system and enhance interoperability. According to the road map, the first set of capabilities was delivered by the end of September 2014 and included access to the Joint Legacy Viewer and a foundation for future functionality, such as an enhanced graphical user interface and enterprise messaging infrastructure.

Another interoperable capability that is expected to be incrementally delivered over the course of the VistA modernization program is the enterprise health man-

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[11] Department of Defense and Department of Veterans Affairs Joint Executive Council and Health Executive Council, *Report to Congress on Department of Defense and Department of Veterans Affairs Medical Information Technology,* required by the explanatory statement accompanying Department of Defense Appropriations Act 2010 (Public Law 111–118).

[12] Booz Allen Hamilton, *Report on the Analysis of Solutions for a Joint DOD–VA Inpatient EHR and Next Steps,* Task Order W81XWH–07–F–0353: Joint DOD–VA Inpatient Electronic Health Record (EHR) Project Support, July 2008.

[13] GAO, *Electronic Health Records: VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration,* GAO–14–302 (Washington, D.C.: Feb. 27, 2014). See also GAO, *2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits,* GAO–14–343SP (Washington, D.C.: Apr. 8, 2014), and *2015 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits,* GAO–15–404SP (Washington, D.C.: Apr. 14, 2015).

[14] Technical interoperability refers to the ability of multiple systems to be able to transmit data back and forth.

agement platform.[15] The department has stated that this platform is expected to provide clinicians with a customizable view of a health record that can integrate data from VA, DOD, and third-party providers. Also, when fully deployed, VA expects the enterprise health management platform to replace the Joint Legacy Viewer.

However, a recent independent assessment of health IT at VA reported that lengthy delays in modernizing VistA had resulted in the system becoming outdated.[16] Further, this study questioned whether the VistA Evolution program to modernize the electronic health record system can overcome a variety of risks and technical issues that have plagued prior VA initiatives of similar size and complexity. For example, the study raised questions regarding the lack of any clear advances made during the past decade and the increasing amount of time needed for VA to release new health IT capabilities. Given the concerns identified, the study recommended that VA assess the cost versus benefits of various alternatives for delivering the modernized capabilities, such as commercially available off-the-shelf electronic health record systems, open source systems, and the continued development of VistA.

In speaking about this matter, VA's Under Secretary for Health has asserted that the department will follow through on its plans to complete the VistA Evolution program in fiscal year 2018. However, the Chief Information Officer has also indicated that the department is taking a step back in reconsidering how best to meet its electronic health record system needs beyond fiscal year 2018. As such, VA's approach to addressing its electronic health record system needs remains uncertain.

In summary, VA's approach to pursuing electronic health record interoperability with DOD has resulted in an increasing amount of standardized health data and has made an integrated view of that data available to department clinicians. Nevertheless, a modernized VA electronic health record system that is fully interoperable with DOD's system is still years away. Thus, important questions remain about when VA intends to define the extent of interoperability it needs to provide the highest possible quality of care to its patients, as well as how and when the department intends to achieve this extent of interoperability with DOD. In addition, VA's unsuccessful efforts over many years to modernize its VistA system raise concern about how the department can continue to justify the development and operation of an electronic health record system that is separate from DOD's system, even though the departments have common system needs. Finally, VA's recent reconsideration of its approach to modernizing VistA raises uncertainty about how it intends to accomplish this important endeavor.

Chairman Kirk, Ranking Member Tester, and members of the subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have.

Senator KIRK. Thank you. Dr. Thompson, we will hear your statement.

DEPARTMENT OF DEFENSE

STATEMENT OF DR. LAUREN THOMPSON, DIRECTOR, DOD/VA INTERAGENCY PROGRAM OFFICE

Dr. THOMPSON. Chairman Kirk and Ranking Member Tester, thank you for the opportunity to address the Subcommittee on Military Construction and Veterans Affairs. I am honored to represent the Department of Defense and Department of Veterans Affairs as Director of the DOD/VA Interagency Program Office, or IPO.

As part of the current strategy to achieve the President's goal of electronic health record interoperability and modernization, the IPO was re-chartered in 2013 to serve as the single point of accountability for identifying, monitoring, and improving the health

[15] The enterprise health management platform is a graphical user interface that is intended to present patient information to support medical care to the veteran from a standardized set of information, regardless of where the veteran receives care. Clinical information captured at the point of care is made available to all authorized providers across the enterprise.

[16] *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veteran Affairs, Integrated Report* (Sept. 1, 2015).

data standards to create seamless integration of health data between the DOD, the VA, and private healthcare providers.

Health data interoperability is essential to improving the care delivered to our servicemembers, veterans, and their beneficiaries. Working closely with the Office of the National Coordinator for Health Information Technology (ONC) and standards development organizations, the IPO helps identify, implement, and map the appropriate national standards associated with both Departments' electronic health record systems.

Assisting the Departments with their interoperability and modernization milestones, the IPO serves as a central resource as DOD and VA develop, adopt, and update a technical framework that is clinically driven to align identified standards with approved use cases.

To that end, the IPO monitors industry best practices and provides technical guidance to facilitate data interchange between the Departments. We also serve as a conduit for the Departments' engagement with ONC and standards development organizations to facilitate knowledge sharing on a national level.

We have been integrated into ONC's planning for a national health IT ecosystem and we are key contributors in the development of ONC's nationwide interoperability roadmap that seeks to advance nationwide health IT.

The IPO also plays an important role in monitoring the progress that DOD and VA continue to make in enhancing their interoperability efforts. Specifically, we have established a health data interoperability metrics dashboard to identify Department-specific targets for transactional metrics and trends.

In addition to these efforts, last year the Government Accountability Office recommended that DOD and VA adopt outcome oriented metrics to provide a basis for assessing and reporting on the progress of the Departments' interoperability efforts. We concurred with GAO's guidance, and I am pleased to report that we have made substantial progress addressing the recommendations.

Specifically, we have been working closely with ONC, DOD, VA, and other public and private partners to develop outcome oriented metrics that not only measure the impact interoperability has on healthcare but specifically focuses on the impact interoperability has on patients and providers.

The IPO is fully committed to assisting DOD and VA as they continue to enhance health data interoperability between their electronic health record systems and the private sector, which will serve as the foundation for a patient-centric healthcare experience, seamless care transition and improved care for our servicemembers, their families, and our veterans.

Again, thank you for the opportunity today, and I look forward to your questions.

[The statement follows:]

PREPARED STATEMENT OF DR. LAUREN THOMPSON

Chairman Kirk and Ranking Member Tester, thank you for the opportunity to address the Subcommittee on Military Construction and Veterans Affairs. I am honored to represent the Departments of Defense and Veterans Affairs as the Director of the DOD/VA Interagency Program Office (IPO).

As part of the current strategy to achieve the President's goal of electronic health record interoperability and modernization, the IPO was rechartered in 2013 to serve as the single point of accountability for identifying, monitoring, and approving the health data standards to create seamless, integration of health data between DOD, the VA, and private healthcare providers.

As you know, DOD and VA are two of our Nation's largest healthcare systems, and share more health data than any two other major systems. Currently, the Departments share more than 1.5 million data elements daily, and more than 100,000 DOD and VA clinicians are able to view the real-time records of the more than 7 million patients who have received care from both Departments.

Health data interoperability is essential to improving the care delivered to our servicemembers, veterans, and their beneficiaries. Working closely with the Office of the National Coordinator for Health Information Technology (ONC) and Standards Development Organizations, the IPO helps identify, implement, and map the appropriate national standards associated with both Departments' electronic health record systems. These steps are vital and provide the building blocks necessary for the Departments to achieve health data interoperability as required by the fiscal year 2014 National Defense Authorization Act. In fact, earlier this year the Departments met this requirement and provided certification to Congress that their systems are interoperable with an integrated display of data.

The IPO is a collaborative entity, comprised of staff from both Departments with technical expertise in health data standards and information sharing. Assisting the Departments with their interoperability and modernization milestones, we serve as a central resource as DOD and VA develop, adopt, and update a technical framework that is clinically driven to align identified standards with approved use cases. To that end, the IPO monitors industry best practices and provides technical guidance to facilitate data interchange between the Departments. We also serve as a conduit for the Departments' engagement with ONC and Standards Development Organizations to facilitate knowledge sharing on a national level; we have been integrated into ONC's planning for a national health IT ecosystem, and were key contributors in the development of ONC's Interoperability Roadmap that seeks to advance nationwide IT interoperability.

The IPO also plays an important role in monitoring the progress that DOD and VA continue to make in enhancing their interoperability efforts. Specifically, we have established a Health Data Interoperability Metrics Dashboard to identify Department-specific targets for transactional metrics and trends. We share this and much more information with Congress in our quarterly Data Sharing Reports and regular briefs with Committee staff. In addition to these efforts, last year, the Government Accountability Office (GAO) recommended that DOD and VA adopt outcome-oriented metrics to provide a basis for assessing and reporting on the progress of the Departments' interoperability efforts. We concurred with GAO's guidance and I am pleased to report that we have made substantial progress to address this recommendation. Specifically we have been working closely with ONC, DOD, VA, and other public and private partners to develop outcome-oriented metrics that not only measure the impact interoperability has on healthcare but specifically focus on the impact interoperability has on our patients and providers.

The field of health data is constantly evolving. For the Departments to maintain and enhance the interoperability of their electronic health record systems, we must continue our collaboration with ONC and industry partners to ensure that DOD and VA map their data to the latest national standards, and that ONC and the private sector can continue to learn from our experience.

The IPO is fully committed to assisting DOD and VA as they continue to enhance health data interoperability between their electronic health record systems and the private sector. Enabling health information exchange between EHR systems in DOD, VA, and the private sector will serve as the foundation for a patient-centric healthcare experience, seamless care transitions, and improved care for our servicemembers, their families, and our veterans. As IPO Director, I am happy to answer any questions you may have on the IPO and work of DOD and VA to identify and adopt health data standards.

Again, thank you for this opportunity, and I look forward to your questions.

Senator KIRK. Thank you. Let me start with questions. I will ask LaVerne, since you have been in office for about a year now, and coming out of J&J and Dell Computer, can you give me your first impressions when you came into the VA IT business?

CIO COUNCIL IMPRESSION OF VA IT

Ms. COUNCIL. Thank you for the question. I think one of the biggest surprises was the lack of an integrated data management capability, which I think is critical to being able to share the right information, have the right analytics, and be able to disseminate the information out to everyone.

Also, the number of custom systems, having well over 800 different applications out, that tends to be a fairly high number, and most organizations might have a few but not that many, and also the age of those systems was also something that was surprising to me.

In addition, not having a program or project management office.

OVER 800 VA APPLICATIONS

Senator KIRK. Let me interrupt you to make a key point. What you are telling the committee is you have several hundred customization projects underway to current software that would make you one of the largest software development operations in the country right there at VA, not a core competency for you guys.

Ms. COUNCIL. Most of the work is managed by contractors, to your point, we have about 218 projects going on right now, and the level of customization is a concern because it does make it harder to maintain those systems.

Senator KIRK. Thank you.

Ms. COUNCIL. Thank you.

Senator KIRK. Over to you.

INTEROPERABILITY AND ENTERPRISE HEALTH MANAGEMENT PLATFORM

Senator TESTER. Thank you, Mr. Chairman. Thank you all for your testimony. Secretary Council, you mentioned in your testimony that deployment of the Joint Legacy Viewer (JLV) has been a major step towards interoperability. As you well know, this is a read-only application, and we know the enterprise health management platform (eHMP) will eventually be a replacement, and it will bring more capabilities to add to the record, I would assume.

On April 8, you jointly certified with the DOD interoperability. Could you tell me, number one, how interoperability will be improved as you implement the enterprise health management platform?

Ms. COUNCIL. Thank you for the question. I will start and then I will pass it over to Mr. Waltman to add some more parts to it. Clearly, being able to certify interoperability of the JLV was exciting. We have to date 178,000 users of the JLV today. We have used it to support about 7 million different intentions, and going forward, the eHMP is going to augment it. David, if you want to share some information, that would be great.

Mr. WALTMAN. Thank you, Ms. Council, Senator. The enterprise health management platform is a great opportunity for us to build on the interoperable information exchange base.

Senator TESTER. I got you. Let me cut right to it, because my time is going to be limited. Right now——

INTEROPERABILITY DEFINITION

Senator KIRK. We are getting to the heart of this hearing, would you please define "interoperability" as you understand it from the NDAA?

Mr. WALTMAN. Yes, Mr. Chairman. The NDAA required us to have an exchange of all health record information between the two departments.

Senator KIRK. I will read to you Webster's definition of "interoperability." Interoperability is "The ability of a system to work with and use another system."

Mr. WALTMAN. Understand.

Senator KIRK. In the case of the Joint Legacy Viewer, which is kind of a kludgy Band-Aid that we have. When I talked to Cerner, they told me it does not provide the x-ray data of a patient, so we would say now welcome to the VA, we have no x-ray data on you from all the x-rays, the Navy, the Army, Air Force did for you.

Mr. WALTMAN. Yes, Mr. Chairman. Agree and understand that definition.

Senator KIRK. I think most members of this committee would say that is not interoperable.

Mr. WALTMAN. Understand. I think that——

JOINT LEGACY VIEWER AND IMAGING ISSUES

Senator KIRK. What about CAT scans?

Mr. WALTMAN. Right. The data that we are exchanging now is all of the health record data, which includes 25 domains of standardized data where standards exist, so that includes progress notes, lab reports. It includes the reports from all of those imaging studies.

As we know, the size of data for the studies themselves is exponentially larger than——

Senator KIRK. If we had a veteran who had a spot on his lung indicating cancer, the Joint Legacy Viewer would not share that with the VA so VA would not know about that emerging cancerous situation, is that correct?

Mr. WALTMAN. I think Dr. Nebeker may be able to answer this question in a clinically precise way, but I would say there would be a radiology report from the study that was done identifying the spot, and that report is available today.

Senator KIRK. This is a narrative thing?

Mr. WALTMAN. That is correct.

Senator KIRK. I am actually talking about the imagery.

Mr. WALTMAN. Right.

Senator KIRK. Most people would think that a medical record includes x-rays that they had taken when they were in the service.

Mr. WALTMAN. Yes, and that is certainly part of the medical record, and the report that the radiologist completes after such imaging studies are done are what other providers typically use to address findings from those reports and follow their course of care.

That said, we are working and in the process now of delivering the image viewer component of the Joint Legacy Viewer, which will be available in the next release, and now the challenge there is to

make sure that we have the bandwidth and ability to exchange the images when they are needed to be exchanged for clinical purposes.

I think the point was that we wanted to ensure we have interoperability and exchange of all the clinically relevant information, so Dr. Nebeker, you may want to make a comment about images and reports and their relevance.

Dr. NEBEKER. Images are critical to the provision of medicine. In most cases the narrative is the most important part of that because as people are planning operations or leading up to an operation or planning treatment, most of us—I am a geriatrician and primary care provider as well as a consultant, I usually rely on the interpretation because I am not expert in all the various domains of radiology to make those types of calls.

Definitely for many types of operations, it is critical to have the images, so we agree with your statement.

For the interoperability, certification of interoperability, there was fairly clear instruction in the statute and also in the response, and Ms. Thompson may be able to take this on a little bit more, but interoperability is a concept. You brought up the dictionary. It is really critical to have use cases about what are the problems we are trying to solve with interoperability.

Clinicians, between VA and DOD, jointly developed a number of use cases, and the conditions for interoperability were meant for those use cases. Ms. Thompson, if you would like to elaborate.

Senator KIRK. This is the only subcommittee that has joint jurisdiction of both DOD and VA, so we are the only guys that can really ride herd on something like bringing you two together, DOD and VA together.

Senator TESTER. I just want to continue real quick. I actually am going to be very interested to hear Dr. Cassidy's questions on this because you are in the business.

You were asked a question and your response was what we are trying to solve here, what we are trying to solve here is not have to rewrite the book again. Quite frankly, where the person was hurt, how the person was hurt, the x-rays, the CAT scans, all that would be on there so that when a veteran is going to get rated, it would be a much easier process, and it would not take forever, and it would not be like a very complicated math problem. It would be right there.

The information has to be there. It is interesting that you would say the notes are more important than the pictures. I am not a doctor, but do you ever do a surgery and not look at pictures of the x-rays and that kind of stuff? You just start cutting based on notes?

Dr. NEBEKER. Yes, sir, I completely agree that for operations the pictures are critical.

FULL INTEROPERABILITY TIMETABLE

Senator TESTER. Okay, good. The question is when and at what point in time are we going to be interoperable to the point where the information that the DOD has, and by the way, if it is not good information coming to you, you do not have good information, but assuming they give you the information, you will have all the information on those medical records in your hands, when is that going to happen?

Ms. COUNCIL. The image viewer is going into deployment to get these images moved into the JLV——

Senator TESTER. When does that happen?

Ms. COUNCIL. September of this year.

Senator TESTER. You will have access to x-rays, CAT scans?

Ms. COUNCIL. Of the records that are in JLV, yes. In addition, I think it goes one step further, and the one step further is why I think enterprise data management is so important. You are both 100 percent correct.

We have to have seamless movement of that information from DOD as far as I am concerned at the Active Duty point of the enlisted person, even knowing before they become a veteran, and we have to work on that. That is one of the reasons that the enterprise level is so important versus just having a pipe that is only health.

Remember, there is much more to the veteran than just their healthcare. It is their benefits, it is their ability to use our National Cemetery System, it is all the things they have a right to, education, and we have to do a much better job of creating that seamlessness.

To your point, the semantic use of that information is that information comes one to one, and the veteran does not have anything to do to ensure that we have their data. That is the most important thing and that is what we are striving for.

Senator TESTER. I have got it. I have been here almost 10 years now, and I serve on the Senate Veterans' Affairs Committee, as does Senator Cassidy, as does Senator Murray and others, as well as Senator Boozman.

The very first meetings that I was at in Senate Veterans' Affairs, we talked about interoperability between the DOD and VA. That was in 2007. We are 10 years later. We have had incredible advances in technology, just flying up through the roof. Yet I still have the feeling——

JOINT LEGACY VIEWER LACKING ANALYTICS

Senator KIRK. If the Senator will suspend, I want to add on to that. When I talked to Cerner this morning, they talked about something that really addresses a key VA priority, which is suicide prevention. I understand from the press we had the suicide hotline that had not enough responses for people. One of my constituents had called in and also committed suicide after they called back.

The exciting thing for what Cerner told me was they had an algorithm that could predict suicide likelihood. When I talked to Cerner, they said the Joint Legacy Viewer cannot do analytics like this.

David, you are nodding your head. This critical upgrade in suicide prevention, they are not capable of doing with this Joint Legacy Viewer.

Senator TESTER. You talked about the images coming in in September. When do you get to a point where you are satisfied with the transfer of information being complete, to deal with issues like the chairman said and others?

Mr. WALTMAN. Thank you, Senator. I was nodding my head because I agree 100 percent, JLV is 100 percent incapable of those analytics. JLV, of course, was——

ANALYTIC CAPABILITY

Senator TESTER. Okay, I have you. When do we get to a point where you are capable of those analytics?

Mr. WALTMAN. That is the enterprise health management comes in, health management platform, and I will allude to the concept of the digital health platform which Ms. Council has talked about.

We need an integrated capability of all the clinical data for process management, for managing clinical pathways, clinical workflows, integrated with analytics which can use algorithms such as described by the chairman, which can predict based on the information in the record, based on pathways and courses of action available, what interventions should be taken and what the processes and care pathway should be.

Dr. Nebeker can talk in a little bit more detail about clinically what that looks like.

Senator TESTER. Do not have to do that. I asked you a question, and the question was when are you going to be able to do this. I am going to tell you I can filibuster you better than you can filibuster me. The question is pretty clear, and you are smart people. Tell me when you are going to be able to achieve this level. That is it. Is it going to be next year, 5 years, 10 years, next month?

Mr. WALTMAN. 2018.

Senator TESTER. 2018. January 1, 2018?

Mr. WALTMAN. The end of fiscal year, so middle of calendar year 2018.

Senator TESTER. When we have this hearing on July 15, 2018, you are going to be totally interoperable, absolutely there is going to be no gaps, the system is going to work?

Mr. WALTMAN. I would like to give a yes or no answer to that question but I cannot. What I can tell you is that we will have the ability to incorporate all of the information between the Departments, to use it, process with the type of algorithms that are being discussed, but I cannot say that every use case that we may have identified for use of interoperable data will be used.

Senator TESTER. Thank you. Thank you, Mr. Chairman.

Senator KIRK. Mrs. Capito.

Senator CAPITO. Thank you, Mr. Chairman. I want to thank all of you as well. I guess I am going to say I am a bit confused because Secretary Council said that on April 8, you were certified interoperable. Then Ms. Melvin said that an interoperability system is still years away. I think that was part of your statement.

Help me with those—that seems like a direct conflict there. Are we talking about the same thing? How do I square those two statements?

Ms. COUNCIL. I am going to try to simplify this and talk in normal ease versus technical ease.

Senator CAPITO. Thank you. I am grateful for that.

Ms. COUNCIL. Let me start with the concept of a system. The system, if you want to think about it, the inner workings, the system, what all works together. The data is the artifact coming out of the system, going into the system, and it actually can sit separately from the system—data, system.

I think Ms. Melvin was referring to an engaged system, being on the same system platform, and therefore, assuming interoperability would be driven by being on the same system platform.

SINGLE VA AND DOD EHR SYSTEM

Senator CAPITO. What is the objection of having a single system, as she mentioned?

Ms. COUNCIL. The reality of a single system, in order for you to ensure that you are going to drive the same level of data out of that system is that you would have to sit on the same instance, time of that system, not just the same name system, but the same capabilities, no difference in that system.

Senator CAPITO. Why can we not do that?

Ms. COUNCIL. The reality is there is no system that can support both DOD and VA at the same time, it will not scale.

Senator CAPITO. We have Amazon that can scale.

Ms. COUNCIL. At the same time, there is no system that will support all the things you have to do, the clinical management and the clinical operations at the same time.

Senator CAPITO. Ms. Melvin, do you have any comment on that?

FULL INTEROPERABILITY

Ms. MELVIN. I would start by saying that we are not trying to define what an interoperable system is for VA. We have been looking at this over the years, and as has been discussed, the question has been and what they have been working toward as we understand it is a fully interoperable capability.

When we talk about fully interoperable, we are asking them to define what they mean by the data exchange, what has to be exchanged, what capabilities and to what extent. Those are questions that have not been answered yet in terms of when you talk about full interoperability, exactly what is it.

What kind of performance measures and metrics would you put in place to know that you have gotten the full capability when you get there.

Senator CAPITO. Excuse me. For the discussion on whether your x-rays and tests and everything are a part of that, are you including that as part of defining what "interoperability" is?

Ms. MELVIN. Absolutely. It is understanding all of the medical information, all of the systems that information would have to come through, and what are they doing in the way of the exchange capability, how will they know when all of the information that they need to ensure that a patient's healthcare is fully taken care of, how will they know when they have gotten to that point or they have a system that gets to that point.

We did encourage one system, and they in fact had stated that one system was the way to go when they went with an integrated electronic health record approach in 2011.

ONE SEAMLESS SYSTEM

Senator KIRK. I would say that they are coming up with two different systems, and the only government bureaucracy that can mandate one system—my preferred outcome would be since La-

Verne owns about 20 million patients and Dr. Waltman owns about 2 million patients, that it is only this committee that can mandate a VA lead to make sure we have one seamless system.

PRIVATE PROVIDERS AND HEALTH INFORMATION EXCHANGE

Senator CAPITO. In my final 2 minutes, let me ask you, Dr. Thompson, because you mentioned private sources, so we have just created the Choice card, we now have our veterans going out to private providers because of the issue of getting an appointment timely, distance, all the things we know exist, and this has been going on in the VA system for a while, but we have expanded it by the Choice card, how is this going to be interoperable with private providers? You have no guarantee.

I will just give you an example in my State, West Virginia, we have a lot of issues with broadband deployment. We just started a broadband caucus yesterday, I did, to meet this issue. What do you anticipate in this area? That is my final question.

Dr. THOMPSON. I can speak to DOD, and I would defer to Ms. Council to speak for the VA. The DOD participates in what is called the eHealth Exchange, which is a public/private partnership of both government, including DOD, providers, and private sector providers, providing data through health information exchange organizations.

Senator CAPITO. Would you say your private providers are on the same e-records as the DOD?

Dr. THOMPSON. For those providers that are participants in eHealth Exchange, they do have access to the DOD data.

Senator CAPITO. There could be providers that were not on the eHealth Exchange?

Dr. THOMPSON. Providers who are not presently on the eHealth Exchange do not have access to that data.

Senator CAPITO. You could have an active military person go to a private physician and they could not be on this eHealth Exchange, and they would not have that data back at the DOD? Am I hearing that correctly?

Dr. THOMPSON. That is correct presently. The DOD is moving aggressively to increase the number of health information exchanges and providers that are participants.

Senator CAPITO. This layers on a whole other issue. Quickly.

Ms. COUNCIL. We do participate in HIE at the VA with over 1,500 of those in the United States. What that is is a standardized data structure, and that is what I was getting to, the data. At the end of the day, that is what you have to have to be interoperable, and you need a standard across that.

Within the United States today, the standard is called health information exchange or HIE, and we participate in those HIEs as a way to engage that information today.

Senator CAPITO. Veterans using the Choice card could go to a physician that is not in the health information exchange and therefore, their records are not interoperable with you?

Ms. COUNCIL. What we do at the VA is if they go to a doctor that is outside of our process, we will reach out to that doctor and get that information one way or the other. If we can get it electronically, we will get it.

One of the things about interoperability, and I just think it is important to remember, it has a continuum. One part of the continuum is non-electronic, which is how we moved things before, I hate to say it, but it is paper. The other one is called semantics, which is data flowing and data moving and talking to each other.

We are on that continuum constantly, and healthcare has been on that continuum constantly, moving to that standard called HIE.

Senator CAPITO. Thank you.

Senator KIRK. With everybody's indulgence, I will do a brief recess so we can make this vote. If you guys can hang loose for a second, since we are paid by the vote here.

[Recess.]

Senator TESTER. I am going to call the hearing back to order. Thank you for your patience. Senator Udall has some very important questions, and we will let him go.

APPOINTMENT SCHEDULING IMPROVEMENTS

Senator UDALL. Thank you, Senator Tester. Thank you so much, and thank you to all the witnesses for being here today, we really appreciate your service to the country and service to our veterans.

My first question revolves around the VA scheduling scandal. Ms. Council, this question is on scheduling, an issue that is critically important to the veterans in my State.

The VA Office of Inspector General recently released a report related to the scheduling scandal from 2014 substantiating claims that the managers at the VA Medical Center in Albuquerque abused scheduling software to manipulate metrics and make it appear the wait times were shorter than they actually were.

This is similar to the earlier reports of scheduling mismanagement in at least seven other States, including Illinois and Arizona.

The findings of this report confirmed allegations that the schedule was rigged to make the center look better. That is very troubling. Our veterans have earned the best care we can provide, the appointment scandal showed a disturbing disregard for health and safety of our heroes.

I have had a chance to discuss the report with the local medical center director in Albuquerque. I appreciate that since I raised these concerns the VA has taken several steps to improve access to care and reduce wait times. That includes extended hour and weekend clinics, same-day primary care clinic, hiring additional staff, and expanding the use of telemedicine.

However, I hear from VA employees and from veterans there is still much work to do. What steps has the Office of Information and Technology taken to eliminate opportunities to game the system, and aside from changes in traditional management practices and training, are there changes that can be made in the software to increase accountability and ensure that these work arounds are no longer possible?

Ms. COUNCIL. Thank you, Senator Udall, for the questions and the background. We agree with you that this is the most important thing, to make sure the veterans have access to the care they need.

To your point, within the VSE product, there is a capability to keep people from having to go in and change, it tracks any change that could be made, and makes sure we can see it.

In addition, there is a product we call Care Now, which is a mobile access for the veteran, which will allow them to actually schedule with a doc in real time, in a telemedicine way, but on a mobile device. We are working with the doctors now to put that into full test.

It was developed to allow the most capable way for the veteran to get help whenever they need it, primarily around mental health, but it could also be used for urgent care. It is a quite nice interactive system. We look forward to sharing that with you as we go forward, but our objective is to make it as seamless and as easy for the veteran to engage.

In addition, their ability to make appointments using a mobile device through a system called VAR, which you have also heard about, which will allow them to request when they want to come in, what date they want to come in, what time, based on what is available.

Trying to put those things in their hands using technology is core and key, but we are really excited about this Care Now application.

Senator UDALL. Thank you. One of the other things I wanted to focus on is Federal information technology management. Many of these problems are caused at least in part by legacy IT.

Ms. Council, I have been working in a bipartisan way with Senator Moran, Senator Milkulski and others on the Appropriations Committee. We want to improve the oversight of how we spend over $80 billion annually on information technology across the Federal Government.

At a hearing following the healthcare.gov Web site debacle, we called for OMB to publish a top 10 list for the highest priority IT investments across the government. We also called for better OMB oversight of these IT projects.

According to the OMB, three of the Nation's highest priority IT projects are at the Veterans Administration. The first one, electronic health records/VistA; the medical appointment scheduling system (MASS); and third, the Veterans Benefit Management System (VBMS).

MEDICAL APPOINTMENT SCHEDULING SYSTEM

Ms. Council, I want to ask specifically about the new medical appointment scheduling system, the scheduling replacement project was terminated in September 2009 after spending an estimated $127 million over 9 years.

What lessons has the VA learned from the failure of its previous scheduling replacement project, which was terminated at the cost I just noted?

Are you using agile or incremental development or best Federal acquisition practices for the new medical appointment scheduling system, and by what dates will the VA's three highest priority IT projects be completed? The three that I mentioned there, VistA, MASS, and VBMS.

Ms. COUNCIL. That was three questions, I want to make sure I address them properly, sir. Upon arrival in 2015, the question of scheduling was on point as what we were going to do with that.

I am going to ask David to share where we are on the scheduling process and also why we decided to do some of the things we have

done, because I think he can give the best feel on that because he has been here.

THREE HIGH RISK VA DEVELOPMENT PROJECTS

On the three key projects, however, that you mentioned, that was brought to my attention immediately upon arrival, that VistA is a 40-year-old system, what we are doing on modernization. The MASS project had just kicked in, and it was all around the scheduling issue and trying to get this right and what we were going to do against that.

The third area was VMBS, which is handling our claims business and how we are going to make that work, and some of the underlying parts of it, including the BDN system, which is over 50 years old.

When you ask when all of those are going to get done, the reality is you always are in a maintenance mode on any sustained application. I would like to say you put them in and never see them again, it is not true.

Applications always cost you, so you are always going to have maintenance, you are always going to be doing patching, you are always going to try to stay ahead of the cybersecurity issues that come with day to day issues on applications.

As far as being done and the capability, I think the reality for us as we talk about EHR and VistA in particular, there are new capabilities that have to be added.

I think the team went forward with an honest and open process for trying to decide what those could be, but we all know we are not able to move fast enough, and did not move fast enough to keep it up to speed where it needs to be, and that is why we are talking about a new platform called the digital health platform.

MASS AND SCHEDULING

On MASS and scheduling, David, if you would give the Senator some of the dates on those.

Mr. WALTMAN. Thank you. Senator, the question about MASS comes back to what Ms. Council referred to in talking about the digital health platform. We made an award of the MASS contract last fall.

That was very soon after Ms. Council and Dr. Shulkin arrived, and under their leadership, we had to look at the bigger picture and whether VistA in the go forward plan made sense.

Since MASS was to be integrated with VistA, with a specific COTS product and had a lot of expense and overhead to do that, while determining what our path forward was, the decision was made to pause MASS.

We have worked since then with the VistA scheduling enhancements, which Ms. Council mentioned, which allows us to do some of the things, auditing, lock down clinical indicated data, things like that, and we are currently working to complete that and have it deployed and is being piloted in three sites right now.

The answer to when MASS will be completed is there is not a completion date determined for that because in the context of discussing our EHR way forward and a commercial off-the-shelf sys-

tem, we have to consider whether we need to address scheduling in that context or separately.

Senator UDALL. Thank you very much, and thank you for your courtesies, Mr. Chairman.

Senator KIRK. Dr. Cassidy.

COMPREHENSIVE DEFINITIONS FOR ALL DATASETS

Senator CASSIDY. First, thank you for that reply, just so it is on the record. I learned from you earlier that VistA—VA is upgrading the VistA system but will eventually replace it with a commercial product.

I know from staff an RFI has been put out, a request for information, to understand what the commercials can do in terms of capabilities for the VA. You have mentioned the enterprise, just for context.

My head was turned around just for a little bit. One of the issues that has been raised for semantic interoperability is comprehensive definitions of all the datasets.

If we wish the VA system and the DOD system to one, talk with one another, and two, talk with providers who are outside your system, has the DOD and VA established a common set of comprehensive semantic definitions? That is my first question to Ms. Thompson, I suppose, and Assistant Secretary Council, and maybe Ms. Melvin.

Ms. COUNCIL. I will pass this over to Dr. Thompson.

Dr. THOMPSON. Thank you for the question. The IPO's role is in working with the DOD and VA for that express purpose. We work with the Office of the National Coordinator and standards development organizations to determine the health data standard that the two Departments should implement in their systems, and we work with them presently through a process of mapping to those standard definitions to ensure that the systems in place in the departments comply with those——

Senator CASSIDY. Yes or no, because that is a lot of "we's." Yes or no, you have established a comprehensive set of semantic definitions or no, but we are working to do so, and are committed to doing so prior to the letting of the contract, and these are or are not compatible with those who might be outside the system but yet providing for those within?

Dr. THOMPSON. Yes, sir, we have established those definitions.

Senator CASSIDY. You have established those definitions? Thank you. These are common as well with the non-DOD/VA providers?

Dr. THOMPSON. That is correct.

APPLICATIONS FOR FUTURE DIGITAL HEALTH PLATFORM

Senator CASSIDY. Secondly, for the DOD, are you all requiring—I believe Cerner is your vendor or one of your two vendors for your EHR, and do you require them to publish their APIs, and do you require they allow plug and play of any future app that might be developed that would allow someone to again put in their blood pressure monitor at home into the EHR, so I guess two questions there.

One, do you require them to publish the API, and two, do you require them to do plug and play, and three, if you do require them, do you require them to do it at a reasonable cost?

Dr. THOMPSON. If I may take those questions for the record, that program falls outside of my particular domain. I would want to make sure I am providing you with the correct information.

[The information follows:]

Unrestricted publishing of APIs is not required; however, the contract provides for all rights necessary to operate, maintain and sustain the EHR system solution; modify interfaces; perform cybersecurity and software assurance; and, train on the EHR system solution, including disclosure within or outside of the Government as necessary to perform these functions.

The contract contains requirements for the integration of future health IT applications or modules, as ordered by the Government once any such applications or modules are identified as requirements by the functional community. Further, in order to simplify the integration of possible future applications, the contract requires adherence to modular open system architecture design and development approaches.

Finally, all negotiations are conducted in accordance with FAR 15.4 which requires establishing the reasonableness of offered prices.

Senator CASSIDY. The VA, and in your RFP, because I am sure you are already thinking about it, again, are you going to require whichever vendor wins to publish the API because for some, it is not proprietary?

I have also been told they effectively limit plug and play even if somebody comes up with a lower cost app, and they limit it by basically charging so much to come up with a custom design to allow the plug that they effectively eliminate the ability to develop plug and play, so my question there.

Ms. COUNCIL. Our recommendation for a digital health platform is that it is all open source and we be able to move in and out of the platform.

Senator CASSIDY. Again, they will be required to publish their APIs as part of the RFP? I see Dr. Nebeker nodding yes.

Ms. COUNCIL. Yes, that is the expectation of our digital platform. We are asking for what is not done today because we feel it needs to be open. That is part of how you drive innovation, and that will be the best way to ensure that we have full interoperability.

Senator CASSIDY. That is good. I have also understood that under your current VistA platform that one of the problems is that each VISN has done a customization of the VistA program for their VISN.

Indeed, VISN 16 does not necessarily communicate with VISN 10 because they have both been customized, you can tell they are related, but they are first cousins, they are not one and the same.

Ms. COUNCIL. Yes, there are 130 plus and distinct instances of VistA within the VHA today.

Senator CASSIDY. So, the modernization process, are you just going to kind of okay, we have to tolerate that until we replace, or are you attempting to reconcile that?

Ms. COUNCIL. I think some of the modernization—I will pass this on—I think much of the modernization is to ensure safety, health, and the clinical side to assure we are capturing the things we need to, just to keep the system whole.

Also, there is security, things we want to make sure the system has the capability to do that might not have been thought about

40 years ago. David, if you would like to share some of the other modernization efforts.

Mr. WALTMAN. Yes, thank you. A key part of the modernization work that we are doing now that will continue into 2018 with the enterprise health management platform is to federate that information from those 130 VistA instances, as we just talked about, because you are right——

Senator CASSIDY. "Federate" implies to me they are allowed to continue to have their own domain.

Mr. WALTMAN. Until we move to a COTS solution on the digital health platform, there is not an intention to collapse all of those instances into one because of time, cost, and complexity.

Senator KIRK. Let me just jump in and have you formally define "federate."

Mr. WALTMAN. "Federate" means that we take all of the health information from those VistAs and bring it into one place so it can be used together. That is what the DHP does.

It also allows us—we have a software development kit to do exactly what you just described, exposing the APIs, people are able to write and provide apps into the platform using that collected, assembled federated data.

DIGITAL HEALTH PLATFORM

Ms. COUNCIL. But to avoid this problem of multiple instances in the future, that is the recommendation, a digital health platform, that we can keep it on one instance, one capability, one solution, and everybody has to come to it. The fact is that 130 is what makes it slow, makes it cumbersome, makes it take a long time, and it makes it inconsistent.

To your point, moving to an open architecture that allows APIs to come in, allows us to use that information, share it, and get it back out and do it in a much more seamless area is where we want to go with DHP.

Senator CASSIDY. I am also told that Cerner has DOD, let's imagine even that Cerner gets VA, as it turns out now, if you have one hospital at Cerner and another hospital with Cerner or Epic and Cerner, there is information blocking. Whether it is because of technological challenges or because of a proprietary instinct is a subject of debate, but nonetheless, it occurs.

What are you all doing in your RFI or RFP to ensure that we will not end up with let's just say technological information blocking?

OPEN SOURCE APPLICATIONS

Ms. COUNCIL. The recommendation that we are making is that is not part of our process, and it will have to be interoperable and have to be open source.

This is an IT recommendation, it is so unusual because we are asking for software as a service component, which changes the way that works, and we are also saying that we would have that level of interoperability, to give you an example, you go in and you fill a prescription at Walgreens, and then you go and you try to fill that same prescription at Rite Aid, it is very hard for you to do it because they have to go get the information.

What we are saying is that would not be the case because they are all based on the same information about you, so they would each see that prescription.

GAO SKEPTICISM ON VA'S ASSERTIONS

Senator CASSIDY. I am taking more time and I apologize, but I want to ask one more question. Ms. Melvin, I was so struck by your skepticism, so we have heard the vision for the VISNs.

Nonetheless, it seems as if you are skeptical. Were you skeptical about the VistA product, coordinating outside of VA, are you skeptical about the VA itself and their vision of a commercial product being able to coordinate outside of VA?

Ms. MELVIN. The questions that we raised really deal with the fact that we have not seen clear planning across VA and DOD relative to what they are trying to achieve.

Senator CASSIDY. Let me ask, would you agree with the statement that they have worked out a comprehensive set of semantic definitions?

Ms. MELVIN. We understand they have from what they say. We are still obtaining information from them. We know they have identified some of the standards that they need. We have not seen other aspects of what they intend to do in terms of putting either the interoperable component together for their systems, between VA and DOD, or the planning that is necessary for VistA modernization.

One of the things——

Senator CASSIDY. Can I ask, have they committed to you a date on which they will provide that information?

Ms. MELVIN. No, we do not have dates yet.

Senator CASSIDY. That seems like a follow up for our committee, that we would also obtain that information because that seems like one of the key issues here, correct? I am sorry, continue.

Ms. MELVIN. One of the points I would make in going back to a statement earlier from Ms. Council where she was saying that they have not identified one system that is large enough to fit their needs, this is the kind of assertion that we would like to see, and that we think it is important for them to have the analysis and the transparency as to why a particular alternative is not sufficient for their needs.

It kind of goes to the overall concern that we have in terms of analysis, planning, looking at the alternatives, and what the departments have in fact done that support where they tend to be at this time, and then of course, the specifics for what it is they are trying to achieve, and how they will know when they get there.

Senator CASSIDY. You have been very generous with your time, thank you, Mr. Chairman.

Senator KIRK. Thank you. Mr. Boozman.

VA'S PLANNING FOR THE EHR FUTURE

Senator BOOZMAN. Thank you, Mr. Chairman. Thank you so much for having the hearing. Can somebody respond to Ms. Melvin's concern about the clear planning?

Ms. COUNCIL. Yes, I can. She is 100 percent correct in what you need to do to provide the kind of background information, and one

of the things that we have done with this recommendation is talk to industry leaders including Gardner Medical, very large medical organizations, as well as the KLAS Group, which is known as the premiere organization for EHR, and they are actually working with us to help us build that business case, look at the various options.

We have a 200-page document which they have gone through and explained to us from the industry perspective on what is out there in COTS, how well they have been received. They talked to over 2,300 providers in these areas about what they are developing, so we are leveraging an independent view as to what makes sense and what will make sense for us, and why certain things do and certain things do not.

Our objective is by the end of this year we will have a business case that the next administration or whomever is there has real data based on an independent group to understand exactly why we made the decisions we did.

ELECTRONIC HEALTH RECORDS AVAILABLE TO JLV

Senator BOOZMAN. Thank you, Ms. Council. I would like to go back to a previous discussion that I did not quite understand. You mentioned the image viewer would go on line this September for those records that are in the JLV. Which records are not in the JLV, and who are you missing?

Mr. WALTMAN. Thank you, Senator. All electronic health records that have been generated in the VA or since DOD has had electronic health records are available and accessible for JLV. That includes anything that would be in AHLTA, for example, on the DOD side, records from back to——

Senator KIRK. David, I will interrupt you since you used the term "AHLTA," that is the data processing system for DOD.

Mr. WALTMAN. Correct.

Senator KIRK. When I was at Walter Reed, the doctors and nurses said that stood for okay, let's all try again.

Mr. WALTMAN. I will not comment on that. The point is not all records that exist for every veteran are electronic, some veterans' records predate the electronic record era. The records that are electronic are in JLV. The images are in a separate image store in both the DOD and the VA, and that is the viewer that is going to allow those to be seen that we are speaking of.

Ms. COUNCIL. Lauren, did you have anything you wanted to add from a DOD point of view?

Dr. THOMPSON. No, I think that was an excellent summary. Thank you.

INDIVIDUAL SERVICE RECORDS

Senator BOOZMAN. Good, that is helpful. I was pleased to hear about the VA's goals with the electronic management platform, particularly with the proposed inclusion of the veteran's service history to include duty stations and type of work they performed during their service, which is really important.

I would like to get a better understanding of how this would work in practice. As you know, servicemembers currently face a very challenging transition from DOD to the VA.

When a servicemember separates from their Active Duty, the information populating their DD–214 is not automatically made available to the VA. It is the veteran's responsibility to make sure the VA has the appropriate documentation in order to verify their service and eligibility for VA benefits.

How would eHMP obtain the member's individual service record?

Mr. WALTMAN. Thank you, Senator. At the present time, the military history feature in the HMP is limited to being able to have a place for information the veteran provides directly. As you said, that is insufficient, and inadequate for seamless care.

It is our desire that with what we have learned about clinical record exchange, health information exchange, with building JLV, that we will be able to work with our DOD colleagues to get the electronic exchange of the service history information and be able to feed that directly into the platform.

Ms. COUNCIL. I think it is broader than just the healthcare. When we look at the totality of the veteran, we are looking at the whole veteran dataset, and our enterprise data management process is putting that backbone across VHA, VBA, NCA, so that way we have the whole look at the veteran, not just pieces and parts, and also we want to mitigate the veteran having to put information into various data marts as they have to do today.

Senator BOOZMAN. When do you anticipate the platform happening?

Ms. COUNCIL. We are beginning that process this year, laying out the architecture, bringing in leadership to guide that, as well as we have set up a governance council so there are data stewards across the organization that will be responsible for that data, and veteran data will be owned and responsible for our veteran experience team.

Senator BOOZMAN. One of the problems that we have is making sure the servicemember's history and data is accurate. What is DOD doing in regard to that? What support would DOD be providing?

Dr. THOMPSON. If I may, I would like to take that question for the record to ensure I provide you with the correct information. That falls outside of my immediate domain of health data standards.

[The information follows:]

Joint Legacy Viewer (JLV) displays servicemember information exactly as it's found in the authoritative system (Clinical Data Repository (CDR), Composite Health Care System (CHCS), Essentris, Theater Medical Data Store (TMDS), etc.). Accuracy is a critical factor DOD tests thoroughly before each release. System Integration Testing tests patient records in test authoritative data sources like the CDR. The testers validate that the data in the disparate data sources matches what is displayed in JLV. Further, the operational test report also specifies that DMIX has information accuracy.

Senator BOOZMAN. Good. Thank you, Mr. Chairman. We appreciate you all being here. This is certainly something that is frustrating in the sense that this has been going on for a long time, and as you can tell, there is uniform frustration. I know you all are frustrated, too, and working hard to get this right.

Hopefully, we will be able to follow up in the near future both in this committee and the Veterans' Committee, DOD, and make

sure that we are moving in the right direction. Thank you very much.

Senator KIRK. Mr. Hoeven.

Senator HOEVEN. Thank you, Mr. Chairman. Ms. Council, you mentioned some of the challenges with your current scheduling systems, specifically not having the capabilities to keep up with the growing Care in the Community program.

In North Dakota, where there has been some challenges with scheduling Veterans Choice appointments, currently the VA is working to implement a pilot project in our State to bring the scheduling aspect back to the VA, instead of relying on the third-party administrator, which in our case is Health Net.

NATIONAL LEVEL IN-HOUSE SCHEDULING

My questions are does VA have the IT system in place to accomplish in-house scheduling on a national level, if not, when will we see an updated scheduling system in place that is capable of managing Care for the Community appointments for Veterans Choice, and what is your near and long-term goal of modernizing your current scheduling system?

Ms. COUNCIL. The first part of that question relates to Care in the Community, which is led by Dr. Yehia, and we are very lock step on that because the Care in Community has a bigger issue with the exchange, as I think you well understand, Senator, so getting to where we can understand what appointment is needed, helping the veteran to make their appointment with the doctor, ensuring that the right referrals are happening, all the things we are doing using the health interchange that we mentioned prior to your arrival.

SCHEDULING SYSTEMS

The scheduling systems, David, I will refer those to you as far as making sure we are straight on the timing and deployment, but the objective was to put in what is called VSC, which is a scheduler that is simpler than what our CPRS system is, and I think that was really the core issue around scheduling, it was convoluted, very difficult to understand.

What you are talking about with the veteran in the community is how best we make sure we know when they want an appointment, and today we are putting in a mobile capability called VAR that will allow them to actually request on their Smartphone or a call, if they have to, if they are not using something electronic, so we could be much more responsive to them.

This is something we are working on daily. As you know, Choice has grown, and then figuring out exactly how to get these hand shakes clear is something we are very committed to. We have to do better. We have a lot more work to do there.

The Choice program and the scheduling program in general are both under engagement, and we are now testing a new scheduling capability in dual locations, looking to roll that out nationally.

Senator HOEVEN. What are those locations?

Mr. WALTMAN. Where that system is being used to see patients are at Ashville VA Medical Center, Salt Lake City, and Cleveland.

SEAMLESS CARE IN THE COMMUNITY

Senator HOEVEN. What I am after, and any one of the three of you from VA who want to take a stab at addressing it, under the old model, when a veteran wanted care, they called the VA, and they either got institutional VA care from a health center or community-based outpatient clinic (CBOC), or they got care through what was called non-VA healthcare. That was in the community.

For the most part, that system seemed to work, not everywhere in the country, but certainly in our part of the country that worked pretty well. They were getting their appointments and they were getting to the VA or to a local private provider if they needed to.

With the third-party providers in place, that system has totally bogged down Veterans Choice, which is creating a real problem. That is why we have the pilot project going in North Dakota, which will serve North Dakota and Western Minnesota. I am very appreciative the VA is doing that, and I am just trying to keep it moving along.

I think somehow nationally we have to get to a more seamless process so veterans are not held up from their appointments, so they get timely appointments, and so that the private providers get paid so they will take those veterans and take them in a timely way, and they are not trying to get payment out of the veteran then rather than the VA.

If you could just address how we are going to get there and how soon we can get there, I would appreciate it.

Ms. COUNCIL. I will come back to you on some of the business issues that are going on with some of the early pay and some of the things Dr. Shulkin and his team are doing to ensure that people get paid faster and quicker.

Getting there and completion requires that we must also sort of know what the program is going to look like in the future. As you know, that is part of the process that is currently ongoing.

We are working very aggressively. We have over 1,500 health interchanges in which information is shared with providers. We are paying early. We are paying faster. We do not want to have that sort of log jam because there has always been a referral process within the VA, but as you know with Choice, it requires that we step further.

A date certain for all completion nationally, I do not have, but I will come back to you with that.

[The information follows:]

The Community Care Scheduling pilot at the Fargo VAMC was initiated in September 2016. The Office of Community Care provided routine updates to Senator Hoeven's office. On August 31, 2016, the Senator and his staff met with VAMC leadership and the Office of Community Care to receive a status update on major milestones for the pilot. The key milestones included contract modifications to the HealthNet contract, union negotiations, process flows and standard operating procedures for implementation, and staff training.

Senator HOEVEN. It seems to me that is a real key for your data systems, to be able to get——

Ms. COUNCIL. It is.

Senator HOEVEN. Mr. Waltman or Dr. Nebeker.

Dr. NEBEKER. The level of interoperability, this is like a wonderful case for interoperability, right, to be able to schedule for a vet-

eran to come to us and say hey, look, we think we can help you better if you go across the street or more locally to your town to get an appointment, let us help you get an appointment.

Technology does exist for this, but we are analyzing the maturity of this technology to see if there is interoperability. University Health Network has some technology for this.

Also, Boston University was doing a pilot several years ago that could do this, and now with North Dakota and Louisiana State University, so we are working with these partners to assess the maturity and suitability to bring these technologies. We look forward to the lessons learned from North Dakota.

Senator HOEVEN. Mr. Waltman, anything you want to add?

Mr. WALTMAN. Thank you, Doctor, you hit the nail on the head there. That is exactly what we are after, and I appreciate you saying so. That is what will serve the veteran. It will serve them through the VA in the best way possible, but also when they need to go to a local provider either for a certain capability or just proximity, distance and time, so thank you. I think that is exactly right, that is what we need to do. I would like to thank all three of you for your work in this area.

Senator HOEVEN. Thank you, Mr. Chairman.

Senator KIRK. Thank you. I will start with my questioning, because I am pretty seized with this issue. LaVerne, when we met, I want to tell you my tale of woe, because I am so focused on this issue.

INCEPTION OF VISTA

Could you please tell the committee when VistA was started, what year?

Ms. COUNCIL. I have seen a date from 1973 to 1975, but in 1975.

HEALTHCARE ANALYTICS

Senator KIRK. I was so concerned about this, I went down to the Smithsonian and went to the Innovations Station Exhibit and took pictures of computers, like this one, the Altair 880, which is considerably younger than all the systems that you have. This was the state-of-the-art in 1975, and for $500, I can get you one.

Is it the state of VistA, it is at this level of technology? Let me follow up. When we got to the heart of this hearing, you certified that you are interoperable based on the JLV's existence, and we now know that the JLV does not have x-rays or CAT scans, and that is interoperable from your viewpoint.

I would say you could expect some further definition from this committee on that point, that we need to move forward on this point to make sure there is no net burden on the soldier and sailor when they come out of the Service, that we 100 percent transfer data to the VA, so that VA can see all the imagery and everything.

In the case of my friend who came back from Iraq, all 38 events in her combat career are included in the record for disability adjudication.

The long term vision that I have, want to make sure that we go with a full blown Apple app on the Apps store. I talked to Cerner this morning. They said they already have several apps through the Apps store. I would like VA—remembering that the average

age of people coming out of Service is going to be about 19, if you are a full blown citizen of the 21st century, you will live on this device.

We are going to have to make sure that there is an app right there with full access to their record, including imagery, to make sure their clinicians can do the analytics.

When I got deeper into this, I realized I was going farther and farther ahead of my own constituents who may not know what analytics does for their healthcare. I would say analytics takes us to the next level.

In the case of being able to predict sepsis or suicide, in the case of Epic, they said in the case of sepsis, that was 54,000 lives that they think were saved by analytics on probability of sepsis.

When I talked to Cerner, they said the Joint Legacy Viewer cannot do analytics of the kind to take us to the next level. I want to make sure that—only this committee, I think, with jurisdiction over military construction and VA, can lean on both bureaucracies.

When I first seized with this issue, I thought let's go with a Mark Kirk version, which would be to make all narratives Microsoft Word, all images JPEG, so we force the bureaucracy to talk to itself and make sure that when you serve the United States in uniform, you can make sure that all of the work the taxpayers already paid for and your medical record is there for the VA.

Ms. COUNCIL. Sir, I think you know from our conversations that I concur with you 100 percent, and just to be clear, our certification of interoperable with JLV was against NDAA section 713(b)(1). It is not to say that it is semantically interoperable, it is not.

Senator KIRK. When you cite that section of the law, it does use the word "interoperable." I want to make sure we are not in a situation where it depends on what the definition of "is" is. We have to get away from that kind of thinking.

Ms. COUNCIL. Totally agree. I think you and I also agree on the fact that having an open platform that will allow new innovation to come to bear, allow us to really use the best and the brightest, and also do more around analytics is core and key to predictive medicine.

This is where the organization is moving, probably not moving as fast as any of us would like, but certainly we understand the value of that, and the value of supporting our veterans with the best.

Senator KIRK. Thank you. I want to go with a full blown Apple app and make sure all these 19 year olds when they come out, they just hit the application and can see a full blown record and can contact VA if they see errors.

Ms. COUNCIL. Yes.

Senator KIRK. And that we move forward on that basis. You will be getting some pretty strong recommendations from this subcommittee on that point.

ADDITIONAL COMMITTEE QUESTIONS

Let me move to closing here. I want to thank everybody for coming today, and especially my partner, Senator Tester. We will leave the record open until the close of next week. Our members may submit questions for the record.

[CLERK'S NOTE: No questions were submitted to the Department for response subsequent to the hearing.]

CONCLUSION OF HEARINGS

Senator KIRK. We stand adjourned.

[Whereupon, at 12:10 p.m., Wednesday, April 10, the hearings were concluded, and the subcommittee was recessed, to reconvene at a time subject to the call of the Chair.]

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

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

NONDEPARTMENTAL WITNESSES

[CLERK'S NOTE.—The subcommittee was unable to hold hearings on nondepartmental witnesses. The statements of those submitting written testimony are as follows:]

PREPARED STATEMENT OF THE AMERICAN PHYSIOLOGICAL SOCIETY

The American Physiological Society (APS) thanks the subcommittee for its ongoing support of Medical and Prosthetic Research at the Department of Veterans Affairs (VA). VA medical research facilities across the country provide veterans access to state-of-the-art healthcare and conduct research that specifically addresses the medical needs of veterans. The APS urges you to make every effort to fund the VA Medical and Prosthetic Research Program at a level of $664.7 million in fiscal year 2017.

CHALLENGES FOR VA RESEARCH AND MEDICAL CARE

The VA research program specifically addresses medical needs of veterans, but new technologies and treatments developed at VA medical centers lead to healthcare improvements for all Americans. VA scientists have done seminal research into rehabilitation following traumatic injury, development of state of the art prosthetic devices to recover functionality, and treatment for post-traumatic stress disorder, traumatic brain injury, and mental health issues including suicide. These medical problems are more prevalent among veterans but are also common in the general population. VA research also explores other conditions such as dementia, diabetes, pain, addiction and cancer and offers hope for the veteran and non-veteran alike. The research carried out in these areas and their resulting innovations will be particularly important in the coming decades as an aging population brings new challenges to the American healthcare system.

VA scientists are increasing research on issues specific to female veterans to better understand gender-specific healthcare needs, women's experiences in service, and future health risks. The VA also has a long-standing research portfolio aimed at addressing minority healthcare needs and disparities in access, delivery and quality.

BRINGING INNOVATION TO HEALTHCARE

Because most VA researchers are also clinicians caring for patients, the VA research system is ideally situated to foster the translation of basic biomedical research findings into clinically relevant diagnostics and treatment modalities. The VA has developed a number of programs that facilitate the translation of knowledge gained in the lab to use in a clinical setting. One example is the Million Veteran Program (MVP) which collects genetic samples and general health information from 1 million veterans and tracks them over 5 years, creating a wealth of information that will inform research and efforts to improve healthcare.

Finally, in addition to focusing on research and patient care, VA medical researchers also play a critical role in educating the next generation of physician-scientists.

Currently, more than half of all practicing physicians in the US receive some of their training at a VA facility.

INVESTING IN THE FUTURE

In recent years, Congress has increased funding for the VA Medical and Prosthetic Research Program, allowing clinicians and researchers to pursue new ideas that would otherwise go unexplored and expand research in promising areas of science. In order to build on this investment in the VA research enterprise, the APS joins our colleagues at the Federation of American Societies for Experimental Biology in urging you to appropriate $664.7 million for VA Research in fiscal year 2017. This level of investment will allow the VA to maintain their current research program while pursuing new directions to address the needs of the veteran population.

ABOUT THE AMERICAN PSYSIOLOGICAL SOCIETY

The APS is a professional society dedicated to fostering research and education as well as the dissemination of scientific knowledge concerning how the organs and systems of the body work. The Society was founded in 1887 and now has more than 10,000 member physiologists. Our members conduct research at colleges, universities, medical schools, and other public and private research institutions across the U.S., including VA facilities.

PREPARED STATEMENT OF THE FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

The Federation of American Societies for Experimental Biology (FASEB) respectfully requests a minimum of $664.7 million for the VA Medical and Prosthetic Research Program in fiscal year 2017. This funding level is needed to keep pace with inflation and sustain support for research on conditions common among service members returning from conflicts overseas, as well as the aging veteran population from previous eras.

FASEB, a federation of 30 scientific societies, represents 125,000 life scientists and engineers, making it the largest coalition of biomedical research associations in the United States. Our mission is to advance health and welfare by promoting progress and education in biological and biomedical sciences.

The Department of Veterans Affairs (VA) Medical and Prosthetic Research Program provides leadership in creating discoveries and developing innovations that advance healthcare for our veterans. Outcomes from this research, however, provide benefits to the entire Nation. Research supported by the VA serves as a model for how scientific inquiry and innovative thought can transform medicine.

It is an obligation to provide the highest quality care to those who have made great sacrifices in service to this country. More than 70 percent of VA researchers are also clinicians who provide direct patient care, allowing the agency to quickly translate discoveries in the laboratory to healthcare improvements. VA-clinician investigators identify new research questions at the patient's bedside and also undertake a wide array of research to improve the lives of veterans.

VA-funded research has produced significant returns, from advancing basic knowledge about disease mechanisms to the development of new treatments and therapies. Partnerships between VA and biotechnology companies have led to the creation of state-of-the-art prosthetics, including a bionic ankle-foot that is now in clinical use and systems that activate residual or paralyzed nerves, muscles, and limbs. In addition, a unique collaboration between VA researchers and private pharmaceutical companies supported a successful clinical trial that led to the development of a vaccine for the shingles virus. Previous VA clinical trials and studies found that vitamin E can significantly delay functional decline among those with mild to moderate Alzheimer's disease and helped shape national guidelines on the use of statin drugs for patients with high cholesterol.

Additional examples of VA-supported research include:

—*Nano-Scale Bone Regeneration Technology:* Researchers from the Atlanta VA medical center have developed a new method for regenerating bone that could lead the way into a new realm of osteoporosis therapies. The researchers were able to promote regeneration of bone in laboratory mice by injecting tiny, ball-shaped particles covered in silica. These studies of silica nanoparticle therapies will shed light on the precise mechanisms of bone formation and repair, and

may one day lead to the development of reliable treatments for bone degeneration.[1]

—*microRNA Cancer Therapy:* Small RNA molecules called microRNAs are crucial regulators of genes throughout the genome. Scientists at the VA Northern California Health System have discovered a particular microRNA that seems to be deficient in bladder tumors. The team subsequently was able to demonstrate that reintroduction of this microRNA molecule reduces tumor cell viability and is now exploring ways in which such molecules might be translated into effective therapies.[2]

—*Genomic Medicine at the VA:* As part of the president's Precision Medicine Initiative, the VA is undertaking the Million Veterans Program (MVP). The program is collecting genomic and other health data from a million veterans in the hopes of finding medical solutions for the ailments afflicting our Nation's veterans and the broader American public. For example, in a pilot study using MVP data, VA researchers are looking at how genetics might predict patients' response to antidepressants, thus informing how best to treat depression.[3]

—*Heart Attack Detection Technology:* In the event of a heart attack, rapid access to care is critical in order to prevent damage to the heart muscle and to save the patient's life. Researchers at Michael E. DeBakey VA Medical Center in collaboration with Baylor College of Medicine have begun to develop a technology that can use a person's saliva to rapidly diagnose heart attacks when chest-pain or other symptoms are first reported. This new technology has the potential to increase both the speed and accuracy of heart attack diagnosis, thus greatly improving outcomes for heart diseases sufferers.[4]

—*Personalized Medicine for Pain Management:* Millions of Americans suffer from chronic pain. By investigating the genetic underpinnings of a specific type of agonizing chronic pain called "Man on Fire Syndrome," researchers at the West Haven VA and the Yale School of Medicine were able to discover an association between a particular protein variant and a positive response to a pain-killing drug. This finding opens up the possibility for pain treatments tailored to specific patients based on their individual genotypes.[5]

SUSTAINED RESEARCH EFFORTS ARE CRITICAL TO MEETING INCREASED DEMAND FOR HEALTH CARE SERVICES

VA research efforts support innovations in care for the growing population of veterans and non-veterans with chronic illnesses. Hearing loss is the most common service-connected disability in the VA healthcare system and affects nearly 30 million Americans. Research funded by the VA is examining new methods of harnessing technology to diagnose and treat individuals with hearing disorders. In addition, the VA is at the forefront of developing treatments to restore vision and design new assistive devices for the nearly 1 million veterans who are estimated to be coping with severe visual impairments.

The demand for mental health services is especially acute. Approximately one in five veterans who served in Iraq and Afghanistan currently have Post Traumatic Stress Disorder (PTSD) and 300,000 VA patients seek treatment for major depressive disorder annually. From fiscal year 2013–fiscal year 2014, the total number of all veterans receiving compensation for service connected disabilities increased by 10 percent even though VA's research budget grew by only 0.6 percent in the same time period.[6]

To address the full spectrum of veterans' healthcare needs and meet the increasing requests for services, the VA Medical and Prosthetic Research Program must be provided with additional resources. The Medical and Prosthetic Research Program will need a budget of $664.7 million (an increase of $34 million over fiscal year 2016) in fiscal year 2017 in order to keep pace with inflation and sustain support for research on conditions common among servicemembers returning from conflicts overseas, as well as the aging veteran population from previous eras. Funds are also required to continue to enhance and further develop the MVP.

FASEB recommends a minimum of $664.7 million for the VA Medical and Prosthetic Research Program in fiscal year 2017 to address the healthcare problems of

[1] http://www.research.va.gov/currents/0815-6.cfm.
[2] http://www.research.va.gov/currents/june15/0615-6.cfm.
[3] http://www.research.va.gov/currents/1015-2.cfm.
[4] http://news.rice.edu/2010/05/06/diagnosing-heart-attacks-may-be-a-lick-and-a-click-away/.
[5] http://medicine.yale.edu/cnrr/news/article.aspx?id=4412.
[6] http://www.benefits.va.gov/REPORTS/abr/ABR-Compensation-FY14-10202015.pdf.

the veteran population and ensure they receive the high quality care they have earned.

Sincerely,

The American Physiological Society
American Society for Biochemistry and Molecular Biology
American Society for Pharmacology and Experimental Therapeutics
American Society for Investigative Pathology
American Society for Nutrition
The American Association of Immunologists
American Association of Anatomists
The Protein Society
Society for Developmental Biology
American Peptide Society
Association of Biomolecular Resource Facilities
The American Society for Bone and Mineral Research
American Society for Clinical Investigation
Society for the Study of Reproduction
The Teratology Society
The Endocrine Society
The American Society of Human Genetics
International Society for Computational Biology
American College of Sports Medicine
Biomedical Engineering Society
Genetics Society of America
American Federation for Medical Research
The Histochemical Society
Society for Pediatric Research
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Association for Molecular Pathology
Society for Redox Biology and Medicine
Society for Experimental Biology and Medicine
American Aging Association (AGE)
U.S. Human Proteome Organization (US HUPO)

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